

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 01/08/2025
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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY</p> <p>Based on observation, medical record review, resident interview, staff interview, review of facility self-reported incident, and review of the facility investigation report, the facility failed to ensure the safety and psychosocial health of a dependent resident. This resulted in actual harm when Resident #46 experienced sexual abuse while receiving a shower from facility staff. This deficient practice affected one (#46) of three residents reviewed for physical abuse. The facility census was 73.</p> <p>Findings include:</p> <p>Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity, congestive heart failure, asthma, and diabetes mellitus.</p> <p>Review of Resident #46's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Resident #46 was dependent on staff for bathing/showers, toileting, lower body dressing and personal hygiene.</p> <p>Review of Resident #46's shower/bath record revealed he received showers on 12/14/24 and 12/21/24.</p> <p>Review of the nurse progress note dated 12/26/24 revealed a Certified Nursing Assistant (CNA) informed the Director of Nursing (DON) and Administrator of a resident's (#46) concern. An investigation was immediately started and an interview of Resident #46 was conducted by the Administrator. Resident #46 was tearful, distraught, and upset throughout the interview.</p> <p>Review of a facility self-reported incident, dated 12/26/24, revealed sexual abuse by a facility staff member was reported from the victim, Resident #46. On 12/26/24 at 2:15 P.M. it was reported to the Administrator by CNA #200 that Resident #46 stated CNA #100 had allegedly been sexually inappropriate with him while providing personal care.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility investigation notes revealed a witness statement from CNA #200 dated 12/26/24. On 12/23/24, CNA #200 noticed Resident #46 had a shower on 12/21/24 and inquired about the shower on 12/21/24 as CNA #200 worked all week and usually gave Resident #46 a shower or bed bath each morning. CNA#100 overheard CNA #200 ask about Resident #46's shower and replied, I worked on 12/21/24 and scrubbed Resident #46 hard; he should be fine. On 12/26/24, CNA #200 began Resident #46's bath and Resident #46 informed CNA #200 she was being a bit rough; CNA #200 apologized and told the resident she was just trying to do a good job at getting him clean. During care CNA #200 noticed Resident #46 was nervous and in talking with the resident, Resident #46 informed CNA #200 that CNA #100 had violated him by inserting her gloved fingers into his anus. Resident #46 showed CNA #200 with his hands how he was violated four or five times in the month of December 2024. Resident #46 told CNA #200 that he thought it was an accident at first, but it continued to occur. CNA #200 immediately reported the conversation to the Administrator and Director of Nursing.</p> <p>Further review of the medical record for Resident #46 revealed a physician progress note dated 12/27/24 which stated Resident #46 was a [AGE] year-old male in long term care with a previous medical history of heart failure, morbid obesity, diabetes mellitus type 2, and arthritis who was being seen after the resident reported being assaulted while receiving personal care. The resident reported feelings of anxiety and anger following the episode. A skin assessment was performed with the Unit Manager and no bruising or breaks in the skin were noted. The patient initially requested to be transferred to a local hospital for assessment; however, after the Unit Manager contacted the hospital and learned a sexual assault exam must be completed within 72 hours of the assault, Resident #46 declined transfer.</p> <p>Review of Resident #46's care plan updated on 12/27/24 revealed the resident had the potential risk for trauma related to physical and sexual violence.</p> <p>Review of Resident #46's shower/bath record revealed he received showers on 12/14/24 and 12/21/24.</p> <p>Interview with Resident #46 on 01/07/25 at 9:20 A.M. revealed when given a shower the resident laid on the shower bed on his side so the staff could clean his backside. Resident #46 stated he informed CNA #200 that CNA #100 was rough with him four or five times in the month of December, and he did not like the treatment. Resident #46 stated during care CNA #100 would thrust hard on his bottom and would put her gloved finger into his rectum. Resident #46 confirmed CNA #200 asked him on 12/26/24 if something happened to him and he informed her of the incidents involving CNA #100 and that was when he learned from CNA #200 that CNA #100 had bragged to other staff members that she fisted him. Resident #46 stated all the staff were talking about him and third shift staff have refused to provide care due to being afraid he would report them for sexual abuse.</p> <p>Observation of Resident #46 during the interview revealed the resident was tearful and anxious.</p> <p>Interview on 01/07/25 at 10:03 A.M. with CNA #200 revealed a month prior to 12/26/24 she had overheard CNA #100 state she had placed her fist into Resident #46's rectum, and he enjoyed the act. CNA #200 thought it was a rumor, and no one believed CNA #100, so nothing was reported. CNA #200 verified on 12/26/24 when providing a bed bath to Resident #46, the resident began to give her hints that CNA #100 was rough and hurt him during care. CNA #200 stated when she asked Resident #46 about her concerns, he informed her that every time CNA #100 touched his bottom she slipped a gloved finger into his anus, adding this occurred five to six times. CNA #200 stated she informed the resident she was going to report the incidents to the Administrator, and the resident was in agreement.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Administrator on 01/07/25 at 11:10 A.M. revealed CNA #100 was terminated for insubordination after getting into a verbal argument with a Unit Manager in front of a resident earlier in the day on 12/26/24, prior to knowledge of the sexual abuse allegation. The Administrator stated the DON attempted to contact CNA #100, but the phone was out of service. The Administrator added the police were contacted immediately and they have started an investigation.</p> <p>Review of the local law enforcement information revealed on 12/26/24 a police report was filed, and an investigation is ongoing.</p> <p>Review of facility policy titled Abuse, Neglect, and Exploitation undated, revealed abuse meant the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>The deficient practice was corrected on 12/28/24 when the facility implemented the following corrective actions:</p> <p>On 12/26/24, The Administrator filed a Self-Reported Incident for sexual abuse to the State of Ohio.</p> <p>On 12/26/24, resident interviews for abuse concerns were conducted by the Unit Manager on all residents with a Brief Interview for Mental Status (BIMS) score of 10 or higher.</p> <p>On 12/26/24, skin assessments were completed by the Unit Manager for residents with a BIMS score of less than 10.</p> <p>On 12/26/24, the Medical Director was notified of the abuse incident.</p> <p>On 12/26/24, staff interviews were completed by the DON.</p> <p>On 12/27/24, staff education on abuse completed by the Administrator.</p> <p>On 12/27/24, head to toe assessments were completed on all residents with a BIMS of less than 10 by the Unit Manager and the Nurse Practitioner.</p> <p>On 12/27/24, 12/30/24 and 12/31/24, psychosocial interviews with Resident #46 were completed by the Social Worker.</p> <p>On 12/27/24, an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Medical Director, DON, Unit Manager and Administrator to review the incident and the corrective action plan.</p> <p>On 12/28/24, ongoing monitoring was implemented with the Unit Manager or designee to complete weekly audits for six weeks on five residents with BIMS score of 10 and above to ensure residents are free from abuse. These results will be reported to the QAPI committee.</p> <p>Observations of Resident care and staff to resident interaction on 01/07/25 and 01/08/25 throughout the survey revealed residents were treated with dignity and respect.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interviews on 01/07/25 and 01/08/25 with Register Nurses (RN) #110 and #156, Licensed Practical Nurse (LPN) #150 Certified Nursing Assistants (CNA's) #112, #131, #153, #162 and #173 and Laundry Aide #200 were able to identify types of abuse and procedures for escalating behaviors and abuse allegations. They reported they received training on abuse policies and procedures, and reporting allegations of abuse.</p> <p>On 01/08/25, two (#71 and #75) additional residents were sampled and reviewed for abuse. No concerns were identified.</p> <p>On 01/08/25, review of the facilities self-reported incidents revealed there were no further concerns identified regarding abuse.</p> <p>Interviews on 01/07/25 and 01/08/25 with Residents (#23, #33, #48, #71 and #75), revealed no concerns related to abuse. Residents reported feeling safe at the facility.</p> <p>This violation represents non-compliance investigated under Master Complaint Number OH00161152 and OH00160931.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY</p> <p>Based on observation, medical record review, resident interview, staff interview, review of a self-reported incident, review of the facility investigation, review of staff schedules, an employee personnel file and training log, the facility staff failed to report suspected sexual abuse timely. This deficient practice affected one (#46) of three residents reviewed for physical abuse. The facility census was 73.</p> <p>Findings include:</p> <p>Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity, congestive heart failure, asthma, and diabetes mellitus.</p> <p>Review of Resident #46's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Resident #46 was dependent on staff for bathing/showers, toileting, lower body dressing and personal hygiene.</p> <p>Review of Resident #46's shower/bath record revealed he received showers on 12/14/24 and 12/21/24.</p> <p>Review of the nurse progress note dated 12/26/24 revealed a Certified Nursing Assistant (CNA) #200 informed the Director of Nursing (DON) and Administrator of a resident's (#46) concern. An investigation was immediately started and an interview of Resident #46 conducted by Administrator. Resident #46 was tearful, distraught, and upset throughout the interview.</p> <p>Review of a facility self-reported incident, dated 12/26/24, revealed sexual abuse by a facility staff member was reported from the victim, Resident #46. On 12/26/24 at 2:15 P.M. it was reported to the Administrator by CNA #200 that Resident #46 stated CNA #100 had allegedly been sexually inappropriate with him while providing personal care.</p> <p>Review of the facility investigation notes revealed a witness statement from CNA #200 dated 12/26/24. On 12/23/24 CNA #200 noticed Resident #46 had a shower on 12/21/24 and inquired about the shower on 12/21/24 as CNA #200 worked all week and usually gave Resident #46 a shower or bed bath each morning. CNA#100 overheard CNA #200 ask about Resident #46's shower and replied, I worked on 12/21/24 and scrubbed Resident #46 hard; he should be fine. On 12/26/24 CNA #200 began Resident #46's bath and Resident #46 informed CNA #200 she was being a bit rough; CNA #200 apologized and told the resident she was just trying to do a good job at getting him clean. During care CNA #200 noticed Resident #46 was nervous and in talking with the resident, Resident #46 informed CNA #200 that CNA #100 had violated him by inserting her gloved fingers into his anus. Resident #46 showed CNA #200 with his hands how he was violated four or five times in the month of December 2024. Resident #46 told CNA #200 that he thought it was an accident at first, but it continued to occur. CNA #200 immediately reported the conversation to the Administrator and Director of Nursing.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the investigation staff interviews conducted on 12/26/24 staff reported CNA #100 had announced on 12/22/24 she had placed her fist into Resident #46's rectum, and he enjoyed the act.</p> <p>Interview with Resident #46 on 01/07/25 at 9:20 A.M. revealed when given a shower the resident laid on the shower bed on his side so the staff could clean his backside. Resident #46 stated he informed CNA #200 that CNA #100 was rough with him four or five times in the month of December, and he did not like the treatment. Resident #46 stated during care CNA #100 would thrust hard on his bottom and would put her gloved finger into his rectum. Resident #46 confirmed CNA #200 asked him on 12/26/24 if something happened to him and he informed her of the incidents involving CNA #100 and that was when he learned from CNA #200 that CNA #100 had bragged to other staff members that she fisted him. Resident #46 stated all the staff were talking about him and third shift staff have refused to provide care due to being afraid he would report them for sexual abuse.</p> <p>Observation of Resident #46 during the interview revealed the resident was tearful and anxious.</p> <p>Interview on 01/07/25 at 10:03 A.M. with CNA #200 revealed a month prior to 12/26/24 she had overheard CNA #100 state she had placed her fist into Resident #46's rectum, and he enjoyed the act. CNA #200 thought it was a rumor, and no one believed CNA #100, so nothing was reported. CNA #200 verified on 12/26/24 when providing a bed bath to Resident #46, the resident began to give her hints that CNA #100 was rough and hurt him during care. CNA #200 stated when she asked Resident #46 about his concerns, he informed her that every time CNA #100 touched his bottom she slipped a gloved finger into his anus, adding this occurred five to six times. CNA #200 stated she informed the resident she was going to report the incidents to the Administrator, and he was in agreement.</p> <p>Interview with the Administrator on 01/07/25 at 11:10 A.M. revealed CNA #100 was terminated for insubordination after getting into a verbal argument with a Unit Manager in front of a resident earlier in the day on 12/26/24, prior to knowledge of the sexual abuse allegation. The Administrator stated the DON attempted to contact CNA #100, but the phone was out of service. The Administrator added the police were contacted immediately and they have started an investigation.</p> <p>Review of the local law enforcement information revealed on 12/26/24 a police report was filed, and an investigation is ongoing.</p> <p>Review of the staff schedules for 12/14/24 and 12/21/24, CNA #100 was assigned to care for Resident #46.</p> <p>Review of the personnel record for CNA #100 revealed a hire date of 08/14/24. Background checks were completed prior to the hire date. CNA #100's Ohio Nurse Aide Registry was in good standing and expires on 10/01/26. CNA #100 was educated on Resident Abuse and acknowledged it on the day of hire.</p> <p>Review of facility policy titled Abuse, Neglect, and Exploitation undated, revealed abuse meant the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>The deficient practice was corrected on 12/28/24 when the facility implemented the following corrective actions:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/26/24, The Administrator filed a Self-Reported Incident for sexual abuse to the State of Ohio.</p> <p>On 12/26/24, resident interviews for abuse concerns were conducted by the Unit Manager on all residents with a Brief Interview for Mental Status (BIMS) score of 10 or higher.</p> <p>On 12/26/24, skin assessments were completed by the Unit Manager for residents with a BIMS score of less than 10.</p> <p>On 12/26/24, the Medical Director was notified of the abuse incident.</p> <p>On 12/26/24, staff interviews were completed by the DON.</p> <p>On 12/27/24, staff education on abuse completed by the Administrator.</p> <p>On 12/27/24, head to toe assessments were completed on all residents with a BIMS of less than 10 by the Unit Manager and the Nurse Practitioner.</p> <p>On 12/27/24, 12/30/24 and 12/31/24, psychosocial interviews with Resident #46 were completed by the Social Worker.</p> <p>On 12/27/24, an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Medical Director, DON, Unit Manager and Administrator to review the incident and the corrective action plan.</p> <p>On 12/28/24, ongoing monitoring was implemented with the Unit Manager or designee to complete weekly audits for six weeks on five residents with BIMS score of 10 and above to ensure residents are free from abuse. These results will be reported to the QAPI committee.</p> <p>Observations of Resident care and staff to resident interaction on 01/07/25 and 01/08/25 throughout the survey revealed residents were treated with dignity and respect.</p> <p>Interviews on 01/07/25 and 01/08/25 with Register Nurses (RN) #110 and #156, Licensed Practical Nurse (LPN) #150 Certified Nursing Assistants (CNA's) #112, #131, #153, #162 and #173 and Laundry Aide #200 were able to identify types of abuse and procedures for escalating behaviors and abuse allegations. They reported they received training on abuse policies and procedures, and reporting allegations of abuse.</p> <p>On 01/08/25, two (#71 and #75) additional residents were sampled and reviewed for abuse. No concerns were identified.</p> <p>On 01/08/25, review of the facilities self-reported incidents revealed there were no further concerns identified regarding abuse.</p> <p>Interviews on 01/07/25 and 01/08/25 with Residents (#23, #33, #48, #71 and #75), revealed no concerns related to abuse. Residents reported feeling safe at the facility.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This violation represents non-compliance investigated under Master Complaint Number OH00161152 and OH00160931.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on resident interview, staff interview, and record review the facility failed to ensure a dependent resident received timely incontinence care. This affected one (Resident #46) with the ability to affect the 48 incontinent residents identified by the facility. The facility census was 73.</p> <p>Findings include:</p> <p>Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity, congestive heart failure, asthma, and diabetes mellitus.</p> <p>Review of Resident #46's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition, was dependent on staff for bathing/showers, toileting, lower body dressing and personal hygiene.</p> <p>Review of Resident #46's care plan updated on 12/27/24 revealed the resident had the risk potential for trauma related to physical/sexual violence.</p> <p>Review of Self-Reported Incident dated 12/26/24 revealed sexual abuse by a facility staff member was reported by the victim, Resident #46 and was being investigated.</p> <p>Review of Resident #46's physician progress note dated 12/27/24 revealed the resident was a [AGE] year-old male in long term care with a previous medical history of heart failure, morbid obesity, diabetes mellitus type 2, and arthritis who was seen for patient reported being assaulted while receiving personal care. Resident #46 stated he had filed a police report, and the facility was performing an investigation.</p> <p>Observation of Resident #46 on 01/07/25 at 8:00 A.M. revealed his room had a strong odor of feces and his sheets were soiled. Staff were in the process of completing resident care.</p> <p>Interview with Resident #46 on 01/07/25 at 9:20 A.M. revealed staff were talking about him and the third shift staff refused to provide care for fear that Resident #46 would report them for sexual abuse. Resident #46 revealed he had a bowel movement at 12:15 A.M. on 01/07/25 and was not changed until first shift arrived at 8:00 A.M. on 01/07/25. Resident #46 stated he had accessed his call light throughout the night and staff would open the room door and tell him they could not care for him and then close the door.</p> <p>Interview on 01/08/25 at 10:03 A.M. with Certified Nursing Assistant (CNA) #200 revealed third shift CNAs had refused to provide care for Resident #46 on night shift because they were worried the resident would accuse them of sexual assault. CNA #200 verified she cared for Resident #46 the morning of 01/07/25 and the soiled brief had not been changed all night.</p> <p>Interview with Registered Nurse (RN) #110 on 01/08/25 at 1:15 P.M. revealed on 01/07/25 Resident #46 had concerns that the night shift staff refused to care for him and left him in a soiled brief throughout the night.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Activities of Daily Living (ADLs) undated, revealed a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This violation represents non-compliance investigated under Master Complaint Number OH00161152 and OH00160931.</p>		