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	07/02/2025

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 - 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 record review, resident and staff interviews, observations, review of the facility's investigation and incident reports, hospital record review, policy review, and review of an instruction manual, the facility failed to ensure a resident requiring transfers with a mechanical lift was transferred safely. This resulted in Actual Harm on 05/15/25 when Resident #01 fell from a Hoyer lift during a transfer sustaining a fractured lumbar vertebral compression fracture. In addition, the facility failed to ensure Resident #61 received adequate supervision and assistance with bathing to prevent the resident from falling and failed to investigate Resident #61's falls which placed the resident at potential risk for more than minimal harm that was not Actual Harm. This affected two (#01 and #61) of three residents reviewed for falls. The facility census was 73. Findings include: 1. Review of the medical record for Resident #01 revealed an admission date of 09/18/20 with diagnoses of morbid obesity, heart disease, and osteoporosis. Review of the care plan updated 10/09/23 revealed Resident #01 had an activity of daily living (ADL) self-care performance deficit and was dependent on two staff for transfers and a mechanical lift. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/31/25, revealed Resident #01 had intact cognition and was dependent on staff for bed mobility and bed to chair transfers. Review of a nursing progress note dated 05/15/25 revealed a loud noise was heard coming from Resident #01's room. Resident #01 was on the ground lying on her back next to her bed in a towel with the mechanical lift above her with a ripped sling pad. Two Certified Nursing Assistants (CNAs) were next to the resident and the mechanical lift. Resident #01 complained of pain in her lower back and shoulder. The CNAs stated they were transferring Resident #01 from the shower bed to Resident #01's bed and the sling pad broke. Emergency rescue services were called, and Resident #01 was taken to the hospital. Review of the hospital records dated 05/15/25 revealed Resident #01 received a computed tomography (CT) scan of the lumbar spine without intravenous contrast and Resident #01 was found to have a second lumbar (L2) vertebrae fracture (likely hyperextension injury in the setting of rigid spine), without significant height loss and no evidence of retropulsed fragment (a piece of bone or disc material that has been displaced backward), favored acute. There was no plan to surgically repair the fracture. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's investigation, initiated 05/15/25, revealed undated witness statements from the two CNAs (#202 and #230) who were present during Resident #01's fall on 05/15/25. Review of the statement from CNA #202 revealed she was assisting CNA #230, who was Resident #01's assigned CNA, in using a mechanical lift to transfer Resident #01 from her bed to a shower bed. CNA #202 stated she would not use the straps on the sling pad to transfer Resident #01 because she could see evidence the straps had been in the dryer. CNA #202 stated CNA #230 could not find another pad and used the one in the room to transfer Resident #01 to the shower bed. CNA #202 stated she put her hands under Resident #01 while transferring her to the shower bed. CNA #202 then assisted CNA #230 when transferring Resident #01 from the shower bed back to her bed after the shower. CNA #202 stated she could not keep her hands under Resident #01 during the transfer because she had to move the shower bed and that was when CNA #202 heard Resident #01 scream and CNA #202 saw three of the straps dangling from the mechanical lift and Resident #01 on the ground. Review of the undated witness statement from CNA #230 revealed when staff were moving Resident #01 back to bed, two of the sling pad straps snapped and Resident #01 slid out to the floor. CNA #230 stated it was the two straps by her legs that snapped. Review of the nursing progress note dated 05/16/25 (created on 05/18/25 and marked as late entry) revealed the interdisciplinary team met to discuss Resident #01's fall on 05/15/25 wherein the sling pad tore during a transfer causing Resident #01 to fall to the floor. The facility-initiated staff education on equipment usage for mechanical lifts and sling pads were checked for wear. The nursing progress note dated 05/16/25 at 8:30 P.M. revealed the facility was notified with an update on Resident #01 from the hospital indicating Resident #01 had an L2 compression fracture and it was non-operable. The nursing progress note dated 05/16/25 at 11:13 P.M. revealed Resident #01 returned to the facility from the hospital. Interview on 06/30/25 at 9:22 A.M. with Resident #01 stated staff were putting her to bed when the green straps broke on the sling pad and she fell to the floor. Resident #01 stated she was sent to the hospital and found to have a crack in her vertebrae and was told it would heal on its own. Resident #01 stated the pain was improving but it continued. Resident #01 also stated after the fall, her whole left side was black and blue, and it was very painful. Resident #01 stated she had noticed straps on the sling pads were broken for several days before the fall and Resident #01 stated she had told several staff but could not remember who she told. Interview on 06/30/25 at 2:20 P.M. with the Administrator, along with a review of CNA #202's statement, confirmed sling pads should not be dried in the dryer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Telephone interview on 06/30/25 at 3:10 P.M. with CNA #202 confirmed she was present during Resident #01's fall from the mechanical lift due to broken sling straps. CNA #202 stated she saw distressed straps, saw little hairs sticking out from the loops on the sling pad used to transfer Resident #01. CNA #202 stated she advised CNA #230 to get another sling and CNA #230 stated she could not find another one. CNA #202 stated when she assisted in transferring Resident #01 from the bed to the shower bed, CNA #202 placed her hands on Resident #01's bottom and assisted in supporting her weight. However, when she and CNA #230 were transferring Resident #01 back to her bed after the shower, CNA #230 raised Resident #01 with the mechanical lift from the shower bed and CNA #202 had to move the shower bed out from under Resident #01. CNA #202 stated she was unable to help support Resident #01's weight and that was when Resident #01 fell from the mechanical lift. Telephone interview on 06/30/25 at 3:40 P.M. with CNA #230 confirmed she was present during Resident #01's fall from the mechanical lift due to broken sling straps. CNA #230 stated she did not observe any concerns with the sling before using it to transfer Resident #01 on 05/15/25. CNA #230 stated she assumed Resident #01's weight and the wetness from the shower caused the straps to snap. Interview and observation on 07/01/25 at 8:34 A.M. with Central Supply (CS) #400 revealed she was given the task of inspecting the facility's sling pads on 05/15/25 for defects after Resident #01's fall. CS #400 stated she found slings with fraying near the loops and on the stitching, and some pads with loose, floppy loops without structural integrity. CS #400 confirmed the loops were used when attaching the sling pad to the mechanical lift and the loops should be stiff and intact. CS #400 stated she also found some sling pads with cut loops. CS #400 stated she could tell the loops were cut because of the clean cut across the fabric. CS #400 stated she did not determine why staff were cutting loops on the sling pads. CS #400 stated she observed the sling pad used to transfer Resident #01 on 05/15/25 and she could see where the loops were frayed after they ripped. CS #400 stated the straps were worn all the way through. CS #400 confirmed the facility determined laundry staff were putting sling pads in the commercial dryer with other linens. CS #400 stated the sling pads should not be put in the dryer because they wore out the material. Observation of a sling pad revealed evidence of the pad being dried in the dryer included white lint debris on the loops, and shrinkage of the sewn-in label. CS #400 confirmed the shrinkage of the label indicated the pad had been dried in the dryer. CS #400 recalled she had not ordered sling pads since the current Administrator began working at the facility in November 2024. CS #400 could not recall when she had previously ordered sling pads. Interview on 07/01/25 at 9:06 A.M. with Laundry Aide (LA) #401 revealed he worked in the facility for over a year and always washed and dried sling pads with linens until he was recently educated to hang dry all sling pads. A follow-up telephone interview on 07/01/25 at 1:49 P.M. with CNA #230 revealed she could not recall CNA #202 advising her not to use the sling pad for Resident #01's transfer on 05/15/25. Review of the email correspondence received on 07/01/25 at 3:02 P.M. from the Administrator revealed she could provide no evidence of historical sling pad purchases prior to the sling pads ordered after Resident #01's fall on 05/15/25. During an interview on 07/01/25 at approximately 3:15 P.M. with the Administrator she revealed she became aware sling pads should only be used for six months before replacement on 07/01/25, after reviewing the Instruction Manual. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the label affixed to the sling pad revealed a warning: Inspect patient slings for wear prior to each use. If signs of tearing, fraying or wear are found, discard the sling immediately; worn-out slings are not safe for use and may result in injury or death. Review of the undated Full Body Sling Instruction Manual revealed slings should be washed in warm or cold water and air dried, or tumble dried at cool or very low temperature. The useful life of the product was six months from the date of purchase under normal use; however, heavy use or excessive washing may reduce the useful life of the product. 2. Review of the medical record for Resident #61 revealed an admission date of 01/26/25 with diagnoses of bipolar disorder, spinal stenosis, and Parkinsonism. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had intact cognition and required substantial/maximal assistance for bed mobility and was dependent on staff for bathing. Review of the Fall Risk Evaluation, dated 01/27/25, revealed Resident #61 was at risk for falls. Review of the care plan initiated 03/05/25 revealed Resident #61 had an activity of daily living (ADL) self-care performance deficit and required staff assistance for bed mobility and bathing/showering. Review of a nurse's progress note dated 05/13/25 revealed CNA #241 came to the writer stating Resident #61 was on the floor. Resident #61 was observed in the room lying on the left side next to the bed close to the wall. CNA #241 told the writer that she was cleaning up Resident #61 and stepped away to wet a towel in the bathroom and Resident #61 fell out of bed. CNA #241 stated she forgot to lock the bed. Resident #61 stated he was trying to get his arm comfortable and next thing you know he was on the floor. Resident #61 complained of hip pain and was sent to the hospital for evaluation. Review of the hospital records dated 05/13/25 revealed Resident #61 did not have any acute fractures. Review of the facility's incident report, dated 05/13/25, revealed Resident #61 was on his side with the bed high in the air and the bed wheels were not locked before the fall. Licensed Practical Nurse (LPN) #300 educated CNA #241 on the importance of locking the bed for safety reasons. Telephone interview on 06/30/25 at 3:01 P.M. with CNA #241 confirmed she was the CNA who was providing care to Resident #61 at the time of his fall on 05/13/25. CNA #241 confirmed she unlocked the wheels on Resident #61's bed while she was providing a bed bath. CNA #241 further confirmed Resident #61 was lying on his right side, facing the wall, when CNA #241 stepped away from him to wet a towel in the bathroom. CNA #241 stated Resident #61 fell between the bed and the wall while she was in the bathroom. CNA #241 confirmed she should have locked the bed wheels before leaving Resident #61 unattended. An interview on 07/01/25 at 10:16 A.M. with Resident #61 stated he recalled falling from the bed between the wall and the bed; however, Resident #61 could not recall whether he was aware the bed wheels were unlocked. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/01/25 at 11:00 A.M. with the Administrator confirmed bed wheels should always be locked. Upon review of the fall on 05/13/25, the Administrator could not provide evidence CNA #241 was interviewed, provided a witness statement or received formal education, beyond that documented by LPN #300 at the time of the incident. Review of the care plan initiated 03/05/25, and most recently updated 06/17/25, revealed Resident #61 was at moderate risk for falls due to gait/balance problems. Interventions included keeping the call light in reach and encouraging the resident to use it, a perimeter mattress, keeping frequently used items within reach (added 04/16/25), providing a reacher [an assistive device designed to help people reach and grasp objects that are difficult to access] (added 05/06/25), staff education (added 05/14/25), and labs and medical work up (added 06/17/25). There were no interventions for a low bed or fall mat. Review of the facility's incident logs, dated 03/30/25 through 06/30/25, revealed Resident #61 fell on [DATE], 05/04/25, 05/13/25, 06/16/25, and 06/17/25. Review of the facility's incident report for the fall on 04/16/25 at 3:33 A.M. revealed Resident #61 had an unwitnessed fall and was found on the floor in his room. Resident #61 stated he was trying to get a phone that fell on the floor. The medical record did not indicate where Resident #61 was prior to the fall, whether in bed or a chair, if the call light was within reach and if it was used, and if the perimeter mattress was in place. Review of the facility's incident report for the fall on 05/04/25 at 10:40 P.M. revealed Resident #61 had an unwitnessed fall and was found on the floor in his room. Resident #61 stated he was trying to get a cord off the floor. The medical record did not state where Resident #61 was prior to the fall, whether in bed or a chair, if the call light was within reach and if it was used, and if the perimeter mattress was in place. Review of the facility's incident report for the fall on 05/13/25 at 9:40 A.M. revealed Resident #61 fell from the bed while being left unattended in an unlocked bed by the CNA while being cleaned. Resident #61 stated he was lying on his side and tried to get more comfortable and before he knew it, he was on the floor. The bed was high up, Resident #61 was on his side and the bed was not locked. Review of the facility's incident report for the fall on 06/16/25 at 11:25 A.M. revealed Resident #61 had an unwitnessed fall in his room and was on the floor wearing an adult brief only. Resident #61 stated he was getting up to go to the bathroom. Some confusion was noted as Resident #61 did not normally walk. Resident #61 was educated on the importance of using a call light for help. The medical record did not state where Resident #61 was prior to the fall, whether in bed or a chair and if the perimeter mattress was in place. Review of the facility incident report for the fall on 06/17/25 at 10:30 P.M. revealed Resident #61 had an unwitnessed fall in his room and was found on the floor in front of his bed. Resident #61 stated he was trying to walk. The contributing factors were confusion and a current urinary tract infection. The medical record did not state where Resident #61 was prior to the fall, whether in bed or a chair, if the call light was within reach and if it was used, and if the perimeter mattress was in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 06/30/25 at 8:40 A.M. revealed Resident #61 lying on a perimeter mattress with a fall mat on the floor beside his bed. Interview on 06/30/25 at 3:21 P.M. with the Administrator confirmed the facility reviewed falls with an interdisciplinary team and would further investigate to gather additional information if all the information was not complete in the incident report. The Administrator stated the additional information would be documented, usually as a progress note, by the nurse who created the incident report. The Administrator further confirmed a thorough investigation was important to determine an appropriate intervention for each resident to prevent similar types of falls. Interview on 07/01/25 at approximately 10:30 A.M. with LPN #300 and concurrent observation of Resident #61 confirmed a floor mat was next to Resident #61's bed. LPN #300 said the fall mat had been there for a while and she assumed it was an intervention because of Resident #61's history of falls. Interview on 07/01/25 at 11:00 A.M. with the Administrator revealed Resident #61's fall mat was a fall intervention and should be included in his care plan. Further interview and concurrent review of Resident #61's falls revealed the previous Director of Nursing (DON) was tasked with completing fall investigations. The Administrator stated she could provide no evidence Resident #61's falls were investigated beyond the creation of an incident report. Upon review of the falls on 04/16/25, 05/04/25, 06/16/25 and 06/17/25 the Administrator could not determine where Resident #61 was prior to the fall, whether in bed or a chair, whether the fall mat was in place, and whether Resident #61 used a call light prior to the falls on 04/16/25, 05/04/25, and 06/17/25. Review of the Fall Prevention Program policy, copyright 2024, revealed the facility would, after each fall, complete a post-fall assessment, complete an incident report, and document all assessments and actions. Fall interventions should be implemented to address unique risk factors for each resident. The policy provided no specific guidance regarding a thorough investigation after a fall. This deficiency represents non-compliance investigated under Complaint Number OH00166353. This deficiency is an example of continued non-compliance from the survey dated 05/22/25.

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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, resident interview, staff interview, observation, and review of facility policy, the facility failed to ensure timely incontinence care was provided and perineal care was provided to promote cleanliness. This affected one (#1) of three residents reviewed for the provision of incontinence care in a facility census of 73. Findings include: Medical record review revealed Resident #1 admitted to the facility on [DATE] with the diagnoses including, coronary artery disease, congestive heart failure, peripheral vascular disease, morbid obesity, and chronic kidney disease stage III. Review of the plan of care dated 10/01/20 revealed Resident #1 was incontinent of bladder and bowel related to decreased mobility and diuretic medications. Interventions included the resident utilized x-large disposable briefs. Change every two hours and as needed (PRN). Check every two hours and PRN for incontinence. Wash, rinse and dry perineum. Change clothing after incontinence care as needed. Provide incontinent care with moisture barrier as needed after incontinent episodes. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had intact cognition, dependent on staff for the completion of activities of daily living, incontinent of bowel and bladder, and at risk for pressure ulcer development. Review of certified nurse aide (CNA) task documentation revealed Resident #1 was checked and changed for incontinence on 06/30/25 at 4:55 A.M. Observation and interview on 06/30/25 at 8:14 A.M. revealed Resident #1 was alert and resting in bed. Resident #1 stated she was soiled of urine and had not been checked for incontinence since approximately 5:00 A.M. Interview on 06/30/25 at 8:41 A.M. with CNA #200 revealed she assumed care of Resident #1 at 6:30 A.M. and was unaware when the resident was last checked for incontinence. CNA #200 went on to state her care assignment included a couple residents that required immediate care and she had not checked Resident #1 for incontinence since assuming care. CNA #200 verified Resident #1 required incontinence checks every two hours due to frequent episodes of incontinence. Observation on 06/30/25 at 8:49 A.M. revealed CNA #200 and CNA #201 entered Resident #1's room and prepared to provide the resident with a bed bath and incontinence care. CNA #200 opened the front of the residents adult incontinence brief and cleansed the resident's torso. CNA #201 proceeded to assist Resident #1 to the right side without cleansing the resident's perineum. Resident #1's adult brief was soiled with a large amount of urine and a small amount of bowel movement. CNA #200 cleansed Resident #1 buttocks, applied barrier cream and placed a new brief on the resident. Interview on 06/30/35 at 9:09 A.M. with CNA #200 verified she did not provide Resident #1 with cleansing of her perineum following an episode of bowel and urinary incontinence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated incontinence policy revealed residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. Review of facility's undated perineal care policy revealed for a female resident, separate the resident's labia with one hand, and cleanse the perineum with the other hand by wiping in direction front to back (from pubic area towards anus). Repeat on opposite side using separate section of washcloth or new disposable wipe. Clean urethral meatus and vaginal orifice using clean portion of washcloth or new disposable wipe with each stroke. Pat dry with towel. Turn resident on her side. Clean and dry anal area, starting at the posterior vaginal opening and wiping from front to back. This deficiency represents non-compliance investigated under Complaint Number OH00166800. This deficiency is an example of continued non-compliance from the survey dated 05/22/25.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interview and review of facility staffing documentation, the facility failed to ensure a registered nurse (RN) worked for eight hours daily in the facility. This affected all 77 residents residing in the facility on 06/03/25. Findings include: Review of the facility staffing schedules dated 06/02/25 through 06/08/25 revealed the facility lacked a RN for eight consecutive hours on 06/03/25. Staffing schedules noted the lack of RN staffing coverage from the beginning of third shift on 06/02/25 until second shift on 06/04/25. Review of facility timekeeping daily staff punches on 06/03/25 lacked evidence indicating an RN was staffed in the facility. Review of the nursing staff information posting from 06/03/25 revealed the facility census was 77 residents. No RN coverage was listed on the nursing staff information posting during all three shifts. On 07/01/25 at 10:25 A.M., an interview with the Administrator verified there was no RN working eight hours consecutively in the facility on 06/03/25. This deficiency represents non-compliance investigated under Complaint Number OH00166415.