

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 07/22/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a facility submitted Self-Reported Incident (SRI), resident and staff interview, review of the facility investigation, medical record review and review of the facility policy, the facility failed to ensure residents were free from neglect when Resident #01 was left outside overnight. This affected one (#01) of three residents reviewed for abuse and neglect. The facility census was 73. Findings include: Review of the medical record revealed Resident #01 was admitted on [DATE]. Diagnoses included cerebral infarction (stroke), traumatic hemorrhage of cerebrum, difficulty in walking, anxiety disorder, unspecified urinary incontinence, parkinsonism (movement disorder), cognitive communication deficit, and nicotine dependence. Review of the Minimum Data Set (MDS) assessment, dated 04/25/25, revealed Resident #01 was moderately cognitively impaired. Resident #01 was always incontinent of bowel and bladder and was (staff) dependent for toileting and chair to bed transfers. Review of the July 2025 Medication Administration Record (MAR) revealed on the nightshift on 07/12/25, the following medications were documented as administered via gastrostomy tube (g-tube - tube inserted through the abdominal wall and into the stomach, used to deliver nutrition, fluids, and medications) to Resident #01: atorvastatin calcium (hyperlipidemia) 10 milligram (mg), buspirone (anxiety) 10 mg, losartan potassium (hypertension) 100 mg, mirtazapine (depression) 15 mg, carvedilol (hypertension) 12.5 mg, levetiracetam solution (seizure disorder) 5 milliliters (ml), magnesium supplement 400 mg, polyethylene glycol packet (constipation), senna tablet (constipation), sodium chloride (hyponatremia), and baclofen (muscle relaxer) 15 mg. Additional review of the MAR for 07/12/25 revealed that Resident #01 received an enteral feed after meals if the resident consumed less than 50% of the meal offered. Jevity (nutritional supplement) was documented as administered at 6:00 P.M. Further review of the MAR revealed Resident #01's g-tube was to be flushed every 12 hours with 60 ml of water to maintain patency. This was documented on the MAR as completed at 8:00 P.M. Additionally, a house supplement was ordered and marked as received, an order for Zyprexa (behaviors/mood affective disorder) 5 mg was documented as refused. Lastly, the MAR included documented blood pressure and pulse for Resident #01 on 07/12/25 nightshift. Review of a nursing progress note, dated 07/13/25 at 6:59 A.M., revealed Resident #01 was not in his room at the time the writer attempted to administer his medications. On inquiry, another resident stated he was outside in the smoke area where he had been all night. Facility staff were immediately sent to bring the resident inside the facility. The writer (Registered Nurse [RN] #241) inquired from the resident as to why he remained outside during the night and he replied that he was cleaning. The note further stated Resident #01 could have periods of confusion. Review of a facility submitted SRI, dated 07/15/25, revealed the facility substantiated an allegation of neglect when Resident #01 was left outside for an extended period, without supervision and personal care provided. On 07/13/25 at 6:12 A.M., it was reported Resident #01 had been left outside on the facility smoking patio all night. Resident #01 was brought back into the facility on [DATE] at 5:53 A.M. Review of the facility timeline, based on review of facility video footage, revealed on 07/12/25 at 6:09 P.M., another resident was observed taking Resident #01 outside to the smoking patio. Resident #01 was observed outside on the patio either by himself or with other residents present throughout the evening. At 10:48 P.M. an unidentified nurse was observed assisting another resident on the smoking patio. Further review of the timeline revealed on 07/13/25 at 12:00 A.M., 1:13 A.M., 2:00 A.M., 3:00 A.M., 4:00 A.M., and 5:00 A.M., Resident #01 was outside (on the smoking patio) with no staff present. At 5:51 A.M., CNA #133 retrieved Resident #01 from the patio. Review of an additional facility timeline document, dated 07/12/25 to 07/13/25, revealed on 07/12/25 at 5:21 P.M., Licensed Practical Nurse (LPN) #154 passed medications at dinnertime. No medications were administered to Resident #01. Medications, which were due at 6:00 P.M., 9:00 P.M., and 10:00 P.M., were signed out (as administered) by RN #241 for Resident #01 at 1:32 A.M. According to the facility timeline, multiple residents continued in and out of the patio until 1:45 A.M. At 6:29 A.M., Certified Nursing Assistant (CNA) #243 marked Resident #01 as unavailable for incontinence care in tasks (CNA documentation system). Review of a witness statement, dated 07/13/25, revealed CNA #243 began work on 07/12/25 at 10:33 P.M. and did not receive report from the nurse or the aide that Resident #01 had moved rooms. CNA #243 stated she had been off for three days and during her previous shift Resident #01 was on a different hall. Review of an electronic mail (email) witness statement, dated 07/16/25, revealed RN #242 reported Resident #01 did not received medication on her scheduled shift (07/12/25 6:00 P.M. to 10:00 P.M.) due to the report that he had eaten more than 50% of</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** Based on medical record review, review of facility Self-Reported Incidents (SRI), staff interview and review of facility policy, the facility failed to report allegations of neglect timely to the State Survey Agency (SSA). This affected one (#01) of three residents reviewed for abuse and neglect. The facility census was 73. Findings include: Review of the medical record review revealed Resident #01 was admitted on [DATE]. Diagnoses included cerebral infarction (stroke), traumatic hemorrhage of cerebrum, difficulty in walking, anxiety disorder, unspecified urinary incontinence, parkinsonism, cognitive communication deficit, and nicotine dependence. Review of the Minimum Data Set (MDS) assessment, dated 04/25/25, revealed the resident was moderately cognitive impaired. Resident #01 was always incontinent of bowel and bladder and dependent on care for toileting and chair to bed transfers. Review of a nursing progress note, dated 07/13/25 at 6:59 A.M., revealed Resident #01 was not in his room at the time the writer attempted to administer his medications. On inquiry, another resident stated he was outside in the smoke area where he had been all night. Facility staff were immediately sent to bring the resident inside the facility. The writer (Registered Nurse [RN] #241) inquired from the resident as to why he remained outside during the night and he replied that he was cleaning. The resident could have periods of confusion. Review of a facility submitted SRI, created on 07/15/25, revealed an allegation of neglect was discovered on 07/13/25 when Resident #01 was left outside on the smoking patio for an extended period of time, without staff supervision or personal care provided. Review of the facility summary investigation, dated 07/17/25, revealed the investigation was ongoing through 07/15/25 and reported untimely to the SSA. Interview on 07/21/25 at 9:30 A.M. with the Administrator verified the incident involving Resident #01 was discovered on 07/13/25 and not reported to the SSA until 07/15/25. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated 2024, revealed the facility would report all alleged violations immediately, but not later than two hours after the allegation was made if the events that caused the allegation involved abuse or resulted in bodily injury or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in bodily injury. This deficiency represents non-compliance investigated under Complaint Number 2568168.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and review of facility policy, the facility failed to ensure smoking assessments were completed for residents who smoked. This affected one (Resident #01) of three residents reviewed for smoking. The facility census was 73. Findings include: Review of the medical record revealed Resident #01 was admitted on [DATE]. Diagnoses included cerebral infarction (stroke), traumatic hemorrhage of cerebrum, difficulty in walking, anxiety disorder, unspecified urinary incontinence, parkinsonism, cognitive communication deficit, and nicotine dependence. Review of the Minimum Data Set (MDS) assessment, dated 04/25/25, revealed the resident was moderately cognitive impaired. Resident #01 was always incontinent of bowel and bladder and dependent on care for toileting and chair to bed transfers. Review of the care plan, dated 07/15/25, revealed Resident #01 was a smoker and interventions included to determine if the resident had a desire to quit, instruct resident on the facility smoking policy, educate on risks and health effects, provide support, and if the resident would like to quit, contact provider. Review of the Smoking Safety Screen, dated 07/15/25, revealed Resident #01 smoked one to two cigarettes a day, typically in the evening, and could not light his own cigarette. Resident #01 was determined to be safe to smoke without supervision. Resident #01 states he only smokes occasionally. Further review of Resident #01's medical record revealed no evidence a Smoking Safety Screen had been completed prior to 07/15/25. Interview on 07/22/25 at 10:47 A.M. with the Administrator verified a smoking assessment had not been completed for Resident #01 until 07/15/25. The Administrator stated the facility was unaware Resident #01 was a smoker until she watched facility camera footage on 07/13/25, related to an investigation she was conducting regarding Resident #01 being left on the smoking patio overnight, and observed him smoking outside. Review of the facility policy titled, Resident Smoking, dated 2024, revealed all residents would be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. Residents who smoked would be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision was required for smoking, or if the resident was safe to smoke at all. This deficiency is an example of continued non-compliance from the surveys dated 05/22/25 and 07/02/25.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility submitted Self-Reported Incidents (SRI), staff interview and review of facility policy, the facility failed to ensure accurate medical records. This affected two (Resident #01 and #21) of three residents reviewed medical record documentation. The facility census was 73. Findings include:1) Review of the medical record revealed Resident #01 was admitted on [DATE]. Diagnoses included cerebral infarction (stroke), traumatic hemorrhage of cerebrum, difficulty in walking, anxiety disorder, unspecified urinary incontinence, parkinsonism, cognitive communication deficit, and nicotine dependence. Review of the Minimum Data Set (MDS) assessment, dated 04/25/25, revealed the resident was moderately cognitive impaired. Resident #01 was always incontinent of bowel and bladder and dependent on care for toileting and chair to bed transfers. Review of the July 2025 Medication Administration Record (MAR) revealed on the nightshift on 07/12/25, the following medications were documented as administered via gastrostomy tube (g-tube - tube inserted through the abdominal wall and into the stomach, used to deliver nutrition, fluids, and medications) to Resident #01: atorvastatin calcium (hyperlipidemia) 10 milligram (mg), buspirone (anxiety) 10 mg, losartan potassium (hypertension) 100 mg, mirtazapine (depression) 15 mg, carvedilol (hypertension) 12.5 mg, levetiracetam solution (seizure disorder) 5 milliliters (ml), magnesium supplement 400 mg, polyethylene glycol packet (constipation), senna tablet (constipation), sodium chloride (hyponatremia), and baclofen (muscle relaxer) 15 mg. Additional review of the MAR for 07/12/25 revealed that Resident #01 received an enteral feed after meals if the resident consumed less than 50% of the meal offered. Jevity (nutritional supplement) was documented as administered at 6:00 P.M. Further review of the MAR revealed Resident #01's g-tube was to be flushed every 12 hours with 60 ml of water to maintain patency. This was documented on the MAR as completed at 8:00 P.M. Additionally, a house supplement was ordered and marked as received, an order for Zyprexa (behaviors/mood affective disorder) 5 mg was documented as refused. Lastly, the MAR included documented blood pressure and pulse for Resident #01 on 07/12/25 nightshift. Interview on 07/21/25 at 9:30 A.M. with the Administrator verified Resident #01 was not administered any medication or treatments from at least 07/12/25 at 6:09 P.M. to 07/13/25 at 5:53 A.M. and further confirmed the nurse had falsified the MAR. Interview on 07/21/25 at 4:14 P.M. with the Director of Nursing (DON) verified that through the facility's investigation into a neglect allegation, it was found that Resident #01's physician ordered g-tube flush and medications were documented as completed; however, the facility determined the treatment and medication had not been provided as ordered. 2) Review of the medical record revealed Resident #21 was admitted on [DATE]. Diagnoses included Type II diabetes mellitus without complications, chronic obstructive pulmonary disease (COPD), unspecified dementia, essential hypertension, and hyperglycemia. Review of the MDS assessment, dated 04/30/25, revealed the resident was cognitively intact. Review of the MAR, dated July 2025, revealed an order for a weekly skin assessment every night shift, every Saturday was signed off as completed on 07/05/25, 07/12/25, and 07/19/25. Review of skin assessments from June 2025 and July 2025 revealed no evidence Resident #21 had a skin assessment completed since 06/21/25. Interview on 07/21/25 at 4:14 P.M. with the DON verified Resident #21's skin assessment had not been completed as documented as completed on the MAR. Interview on 07/22/25 at 10:47 A.M. with the Administrator verified Resident #21 had not had a skin assessment completed since 06/21/25 and the documentation on the MAR indicated it was completed on 07/05/25, 07/12/25, and 07/19/25. This deficiency represents non-compliance investigated under Complaint Number 2568168.</p>		