

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 08/20/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of hospital documentation, and staff interview, the facility failed to administer medications as ordered by the physician. This affected one (#34) of four residents reviewed for medication administration. The current census is 78. Findings include: Record review for Resident #34 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #34 include sepsis, heart failure, dysphagia, sepsis due to enterococcus, gastritis with a gastric ulcer, and encounter for palliative care. Review of Resident #34's comprehensive Minimum Data Set, (MDS) date 08/06/25 revealed the resident had impaired cognition and was receiving parental nutrition via a feeding tube. Review of Resident #34's progress notes dated from 08/11/2025 to 08/19/2025 revealed by the note dated 08/11/25 at 4:18 P.M. Resident #34 was having a choking episode and was transferred to the hospital for treatment. Review of Resident #34's hospital paperwork for discharge back to the facility on [DATE] revealed the resident was ordered to start taking Augmentin (antibiotic) 400-57 milligrams/ 5 milliliters (mg/ml) give 10.9 ml daily orally for 9 days for aspiration pneumonia. Review of Resident #34's progress notes dated 08/13/25 at 3:30 P.M. the resident returned to the facility with a new order for Augmentin oral suspension 10.9 milliliters (m1) oral solution every 12 hours for 9 days for aspiration pneumonia. Further review of Resident #34's physician ordered medication list dated August 2025 revealed the resident was not ordered to start the antibiotic until 08/17/25. No order for the Augmentin antibiotic dated 08/13/25 was noted in the orders. The order dated 08/17/25, revealed Resident #34 was ordered to receive Amoxicillin (antibiotic) 10.9 mls oral solution every 12 hours for 5 days. Review of Resident #34's Medication Administration Record (MAR) dated August 2025 revealed the resident did not receive any oral antibiotic from 08/13/25 to 08/17/25. Interviews on 08/18/25 at 3:30 P.M. and on 08/19/25 at 2:15 P.M., with the Director of Nursing, (DON) verified when Resident #34 returned to the facility the receiving nurse did not include the hospital discharge orders for the Augmentin oral antibiotics. The DON verified the Augmentin oral antibiotic started to be given as physician order on 08/17/25 for 5 days and the resident had missed 8 doses of the medication from 08/13/25 to 08/17/25. This deficiency represents non-compliance discovered during the investigation for Complaint Number 2589259</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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F 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

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F 0805 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, personnel file review, family interview, staff interview, and policy review, the facility failed to ensure a resident who was dependent on tube feeding and ordered nothing by mouth (NPO) was not served food to eat by a staff member. This resulted in actual harm when Resident #34 who was found choking on food after being served a dish of watermelon at the bedside and left alone to consume the watermelon. Subsequently, Resident #34 was sent to the hospital for invasive procedure to dislodge the food from the esophagus. Resident #34 was admitted to the hospital with aspiration pneumonia from choking and aspirating (breathing food into the lungs) on food. This affected one (Resident #34) of three residents reviewed for altered needs for dietary. The facility census was 78. Findings include: Review of the medical record for Resident #34 revealed the resident was admitted to the facility on [DATE]. Diagnoses included sepsis, heart failure, dysphagia, sepsis due to enterococcus, gastritis with a gastric ulcer, and encounter for palliative care. Review of Resident #34's comprehensive Minimum Data Set (MDS) assessment, dated 08/06/25, revealed the resident had impaired cognition and was receiving parental nutrition via a feeding tube. Review of Resident #34's physician ordered diet revealed as of 04/29/25 the resident was ordered to receive nothing by mouth (NPO). The physician order dated 06/03/25 documented the resident was to receive a bolus of Jevity 1.5, via the feeding tube with 75 milliliters (ml) flush before and after bolus five times a day for feeding. Review of Resident #34's care plans, dated 08/18/25, revealed a focus for oral/swallowing risk. Interventions include serving diet per order and consult speech therapy for swallowing issues. Resident #34 required a feeding tube related to weight loss and increased needs. Goals were to be free from aspiration and maintain adequate nutritional status. Interventions for the focus include monitor and report as needed signs of aspiration, infections, and tube dysfunction. Review of Resident #34's progress notes, dated 08/11/25 at 4:18 P.M., revealed Resident #34 was having a choking episode and was transferred to the hospital for treatment. The resident was coughing and yelling while choking. Her vital signs were within normal limits. The resident's family and physician were notified. The medical record documented on 08/11/25, Resident #34 had been admitted to the hospital for a primary diagnosis of a foreign body in esophagus. Review of the hospital records documented on 08/12/25, Resident #34 underwent an esophagogastroduodenoscopy (EGD) procedure to remove the food bolus accumulating in her esophagus. The resident was ordered to remain NPO and continue to receive nutrition via the feeding tube. Resident #34 was discharged back to the facility on [DATE] with a diagnosis of aspiration pneumonia. Review of Resident #34's Computed Tomography (CT) scan, dated 08/11/25 at 8:35 P.M., revealed a finding of a food bolus seen within the distal esophagus, lower in position though more distal compared to prior exam but smaller in size. There was improved aeration (oxygen exchange) in the distal airways involving the lower left lobe, however, cannot rule out aspiration. During an interview on 08/18/25 at 10:21 A.M., Resident #34's family representative stated on 08/11/25, the family was contacted by the facility and was told a staff member in the activities department had given Resident #34 some watermelon. The family stated the nurse informed them the activities aide was not educated on Resident #34's dietary order. The facility nurse stated they called 911 and Resident #34 was transported to the hospital to receive emergency treatment. The family representative stated the hospital informed the family Resident #34 required an upper endoscopy to remove two pieces watermelon lodged in her esophagus and one piece of watermelon was moving into her lungs. While admitted to the hospital, Resident #34 was diagnosed with aspiration pneumonia from choking on the watermelon. During an interview on 08/18/25 at 11:03 A.M., Registered Nurse (RN) #216 stated on 08/11/25 a new aide from activities, Recreation Assistant (RA) #125 was passing out food to residents and RA #125 heard the resident coughing and yelling for help. RA #125 got the nurse, who assessed Resident #34 and found her coughing and drooling, with pieces of watermelon on her shirt. RN #216 stated she took the resident's vitals and called for emergency services to transport the resident to the hospital for treatment. During an interview on 08/18/25 at 11:17 A.M, RA #250 stated she was not the aide who passed the watermelon to Resident #34; however, she was working the day of the incident. The recreation aides are not educated on the resident's dietary restrictions. During an interview on 08/18/25 at 11:25 A.M., Director of Recreation (DOR) #123 stated on 08/11/25, RA #125 was newly hired to the facility and on 08/11/25, RA #125 was passing watermelon during activities. DOR #123 uses the dietary restriction sheet provided to know the resident's diet orders and restrictions. DOR #123 stated she instructed RA #125 to pass snacks on</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observed, review of facility's temperature log, review of facility policy, and staff interview, the facility failed to ensure all food was stored at appropriate temperatures. This has the potential to affect all residents with the exception of Resident #34 and Resident #19 (two residents identified as not receiving any food from the kitchen). The current census is 78. Findings include: Review of the facility's temperature logs dated August 2025 for the refrigerator revealed the lowest temperature for the refrigerator was recorded as 50 degrees with the highest temperature recorded was 65 degrees. Observation on 08/18/25 at 7:16 A.M. during a kitchen tour revealed the walk-in refrigerator temperature gauge read 50 degrees. During the observation there was no internal thermometer observed in the walk-in refrigerator. The walk-in freezer was in the back of the walk-in refrigerator and the outside temperature gauge for the freezer section was noted as -10 degrees. Ice was observed accumulating in the freezer around the fan. Interview on 08/18/25 at 7:16 A.M. with [NAME] #184 verified the walk-in refrigerator was not working properly and the temperature was at 50 degrees. Per [NAME] #184 the staff have been opening the freezer door to cool down the refrigerator portion of the refrigerator section. Interview on 08/19/25 at 2:15 P.M. with Director of Maintenance (DOM) #217 verified since the beginning of August 2025 the refrigerator in the front of the walk-in section was not cooling and keeping the food stored at a temperature below 42 degrees. DOM #217 stated the maintenance staff have put in requests for repairs and are waiting for funding and bids to be approved to repair the refrigerator. DOM #217 stated the kitchen staff have been opening the freezer doors to keep the refrigerator portion cool. DOM #217 verified the temperature of the refrigerator does not stay below 42 degrees during the evening and at times during the day when no staff are available to monitor the temperatures and keep the freezer door open. DOM #217 verified there was ice accumulation in the freezer due to condensation from times when the door is open to the refrigerator. Interview on 08/19/25 at 3:33 P.M. with Director of Dietary (DD) # 219 verified the refrigerator has not been working since July 2025 and the kitchen staff are continuously monitoring the temperatures but can only open the freezer door for short time periods to keep the temperatures in the freezer at appropriate levels. DD #219 stated the kitchen staff have been instructed not to keep eggs, raw meat, or dairy in the refrigerator but inside the freezer to keep food safer. DD #219 verified there were items in the refrigerator that could potentially spoil due to not being kept at a constant temperature. DD #219 stated the maintenance department has had several reports regarding the refrigerator but there is no plan in place for repairs. Interview on 08/20/25 at 10:00 A.M. with the Regional Administrator verified the refrigerator was not maintaining the appropriate temperatures for food storage according to the facility's temperature logs and observations. Per the Administrator, there have been no residents exhibiting signs and symptoms of gastro-intestinal issues relating to food born illnesses. This deficiency represents non-compliance discovered during the investigation for Complaint Number 2578247</p>		