

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  10/27/2025
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 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.  (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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review and facility and oncology staff interview, the facility failed to follow pre-procedure physician orders to ensure the completion of a procedure. This affected one (#56) of three residents reviewed for completion of medical appointments. The facility census was 71. Findings include: Review of the medical record for Resident #56 revealed an admission date of 09/16/25. Diagnoses included heart failure, peripheral vascular disease, and acute respiratory failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Resident #56 was assessed to require total assistance with toileting, and substantial/maximal assistance with bathing, and was dependent for dressing and transferring in and out of bed. Review of the care plan dated 09/18/25 revealed Resident #56 was on anticoagulant therapy (apixaban) related to below the knee amputation. Interventions included administering the medication as ordered by the physician and monitoring for side effects and effectiveness. Review of a progress note dated 09/17/25 revealed a new order was placed for hematology related to myeloproliferative disorder (overproduction of blood cells in the bone marrow). Review of the physician orders dated 09/20/25 revealed Resident #56 had an order for aspirin 81 milligrams (mg) one time a day for coronary artery disease. Further review revealed an order for apixaban (anticoagulant) five mg by mouth two times a day for prevention of blood clots. Review of the after-visit summary dated 09/22/25 at 9:30 A.M. revealed Resident #56 was seen by the oncology clinic for myeloproliferative disorder, and iron deficiency anemia due to chronic blood loss. Resident #56 had new orders for a guided bone marrow biopsy and laboratory (lab) testing. Review of a nursing progress note dated 09/22/25 revealed Resident #56 arrived back from an oncology appointment with a bone marrow biopsy scheduled for 10/01/25 at 9:30 A.M. and a follow-up oncology appointment on 10/20/25 at 9:20 A.M. Review of a physician order dated 09/22/25 revealed an order for Resident #56 to have nothing by mouth (NPO) beginning at midnight on 10/01/25. Review of a nursing progress note dated 09/26/25 revealed Eliquis (apixaban) and aspirin were to be held effective immediately until procedure (bone marrow biopsy) was completed on 10/01/25. Resident #56 was to be NPO at midnight on 10/01/25 and all medications were to be held the morning of the procedure. Review of the October 2025 Medication Administration Record (MAR) revealed Resident #56's NPO order, effective 10/01/25, was not identified on the MAR. Further review of Resident #56's medical record revealed no evidence the bone marrow biopsy was completed on 10/01/25. Interview with the Administrator on 10/20/25 at 9:10 A.M. verified Resident #56 did not have a bone marrow biopsy on 10/01/25, as scheduled. The Administrator confirmed the procedure could not be completed because the staff served Resident #56 that morning and he was supposed to be NPO. The Administrator revealed the unit manager was responsible for following up on procedure preparation and entering any orders into the MAR. Interview on 10/20/25 at 10:19 A.M. with Registered Nurse (RN) #200 with the oncology clinic revealed Resident #56's bone marrow biopsy on 10/01/25 had to be canceled as the facility provided the resident breakfast that morning. The procedure was rescheduled for 10/09/25. On 10/08/25, RN #200 stated she contacted the facility to ensure pre-procedure instructions were followed, including the holding of Eliquis and aspirin for three days prior to the procedure, and discovered the facility did not hold the resident's medication, as instructed. Resident #56's bone marrow biopsy had to be rescheduled for a second time due to the facility not following pre-procedure orders. Additional review of the October 2025 MAR confirmed Resident #56 was administered aspirin and Eliquis on 10/06/25, 10/07/25, and 10/08/25. Interview with Licensed Practical Nurse (LPN) #305 on 10/20/25 at 11:56 A.M. revealed that when a resident returned to the facility with new orders for a procedure, the information was placed in the MAR, and the physician was notified. LPN #305 stated the facility did not have hard/paper charts, so there were delays in uploading important documents into the electronic medical record (EMR). LPN #305 stated report between nurses was verbal, and they had a report sheet. LPN #305 confirmed Resident #56 ate before his appointment on 10/01/25, and that the second appointment on 10/09/25 was cancelled due to staff administering aspirin and Eliquis to Resident #56, and not holding it for three days prior, as instructed. Interview with Director of Nursing (DON) on 10/20/25 at 2:25 P.M. revealed the floor nurse would have been the staff who received the orders for Resident #56's bone marrow biopsy preparation. The DON confirmed that there were no orders in the EMR for the pre-procedure instructions for the bone marrow biopsy scheduled for 10/01/25, resulting in staff providing the resident breakfast on 10/01/25 and cancellation of the procedure. The DON further verified</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on closed record review, review of hospital documentation, staff interview, and review of facility policy, the facility failed to ensure timely assessment, measurement, and documentation of wound descriptions were completed and further failed to ensure physician ordered treatments and skin impairment interventions for a right heel pressure ulcer were initiated timely and completed as ordered. This affected one (#71) of three residents reviewed for pressure ulcers. The facility census was 71. Findings include: Review of the closed medical record for Resident #71 revealed an admission date of 08/01/25. Diagnosis included anemia, Type II diabetes mellitus, and chronic kidney disease. Resident #71 transferred to the hospital on [DATE] due to a change in condition and did not return to the facility. Review of the admission Minimum Data Set (MDS) assessment, dated 08/05/25, revealed Resident #71 was cognitively intact. Resident #71 was assessed to have one venous wound, one stage IV pressure ulcer, and one unstageable pressure ulcer. Review of the care plan dated 08/11/25 revealed Resident #71 required staff intervention to complete self-care and mobility activities and was at risk for decline in functional ability and usual performance. Interventions included assisting with ADLs. Additionally, Resident #71 had diabetes mellitus. Interventions included checking all of body for breaks in skin and treating promptly as ordered by a doctor. Further review revealed Resident #71 had a stage four pressure ulcer to the left distal knee, a stage three pressure ulcer to left lower thigh, and the potential for pressure ulcer development related to the disease process of diabetes mellitus. Interventions included assessing, recording, and monitoring wound healing two times a week on Monday and Thursday, measuring the length, width and depth where possible, assessing and documenting the status of the wound perimeter, wound bed and healing progress, and report improvements and decline to the doctor. Lastly, Resident #71 had a venous ulcer of the left shin related to diabetes mellitus Type II, and moisture associated skin damage (MASD) to the coccyx. Interventions included weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, and type of tissue exudate (drainage), and any other notable changes or observations. Review of a nursing progress note dated 08/02/25 at 4:34 P. M. revealed Resident #71 arrived to the facility from an acute care hospital. Resident #71 had a left below the knee amputation with a prosthetic leg. Resident #71 had wounds to the left stump, front of thigh, and lateral thigh. Lastly, the progress note indicated Resident #71's right leg had healing scars to the knees and black eschar (layer of dead tissue that forms over a wound) to the heel and second toe. Further review of the medical record revealed no evidence the wound to Resident #71's right heel and second toe were assessed, including further description and measurements of the wounds. Review of the physician orders dated 08/03/25 revealed an order for offloading pressure boots in place at all times while Resident #71 was in bed and document all refusals. Additionally, Resident #71 had an order for skin prep to the right heel every day and as needed. Review of the Skin Observation Tools revealed that on 08/08/25, Resident #71 was assessed to have a left below the knee amputation and left lower shin vascular wound (the resident's left leg was amputated below the knee). There was no assessment of the right heel pressure ulcer. Further review revealed on 08/15/25, Resident #71's skin was marked to be intact. There was no assessment of the right heel pressure ulcer. On 08/22/25, the assessment indicated Resident #71 had a pressure wound to the left lower thigh and the left distal knee, with a vascular wound to the left shin (the resident had a left below the knee amputation). There was no assessment of the right heel pressure ulcer. Additional review of the Skin Observation Tools revealed no skin assessment was completed from 08/22/25 through 09/23/25. Review of the Skin Observation Tool completed on 09/24/25 revealed Resident #71 had a pressure wound to the left distal knee and left lower thigh, and a vascular wound to the left shin (resident had a below the knee amputation). There was no assessment completed for the resident's right heel pressure ulcer. Review of the Treatment Administration Record (TAR) for August 2025 revealed no documentation that the skin prep was applied to Resident #71's right heel on 08/14/25, 08/15/25, and 08/20/25. Further review of the TAR for August 2025 revealed no documentation the offloading pressure boots were in place on 08/06/25 and 08/16/25 at nighttime or on 08/14/25, 08/15/25 and 08/20/25 during the day. There was no documentation that Resident #71 refused treatments. Review of the Wound Care Notes from 08/07/25 through 09/08/25 revealed Resident #71 was seen weekly by wound care for the management and treatments of wounds; however, there was no mention of the resident's right heel. Review of the September 2025 TAR revealed no evidence skin prep was applied to Resident #71's right heel on 09/01/25, 09/04/25, and 09/10/25. Further</p>		

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F 0925  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.  (continued on next page)

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, review of pest control records, staff and resident interview, and review of the facility policy, the facility failed to ensure effective pest control in the facility. This affected two (#14 and #19) of three residents reviewed for pest control, and had the potential to affect all 71 residents residing in the facility. The facility census was 71. Findings include: Interview on 10/22/25 at 8:19 A.M. with Registered Nurse (RN) #307 revealed there were an excessive number of flies on the 100 and 200 halls. RN #307 stated the facility had fly swatters on the nurses' carts and in the residents' rooms due to the large number of flies in the facility. Interview on 10/22/25 at 8:55 A.M. with Licensed Practical Nurse (LPN) #301 revealed the facility had flies and gnats so bad that the nurses carried fly swatters during medication pass, and the residents that could use their hands had them in their room. LPN #301 stated there were times when staff would have to swat the flies away from resident's faces who were unable to swat them away themselves. LPN #301 stated the flies had been reported to management and administration. LPN #301 stated there was a mouse in the activities room and on one occasion the activities aide ran out screaming after seeing a mouse. Interview on 10/22/25 at 9:46 A.M. with LPN #309 revealed there were mice in the facility and she had seen them in Resident #14's room. LPN #309 revealed she had bought her own mouse traps and gave them to maintenance to put around due to the facilities pest control not being effective. LPN #309 stated Resident #14 had reported mice in his room to administration. Observation on 10/22/25 at 10:10 A.M. of Resident #14's bedroom revealed multiple flies and gnats in the bedroom. Further observation revealed several flies on the residents' drinking cups and on the bedside table. Concurrent interview with Resident #14 revealed that around 10/19/25, there was a mouse on his bed and, later in the day, a mouse was in front of his chair. Resident #14 stated he reported it to the nurse. Resident #14 stated maintenance came to his room and sprayed peppermint oil around the walls of the bedroom. Interview on 10/22/25 at 10:20 A.M. with Resident #49 revealed a mouse came into his room every day. Resident #49 stated he had reported it to the nurses. Interview on 10/22/25 at 11:16 A.M. with Director of Maintenance (DM) #401 verified mice had been a concern in the facility and stated it had been hard to get rid of the mice in Resident #14 and Resident #49's rooms. DM #401 stated the pest control vendor had been to the facility on [DATE] for a consultation and provided an estimate for a more aggressive treatment for mice. DM #401 stated the facility chose to try to treat them on their own with an organic peppermint oil spray. DM #401 stated on 10/20/25, Resident #14 and Resident #49's rooms were sprayed with the peppermint oil and staff still reported mice sightings. DM #401 stated that the continued rodent activity would need to be taken care of in a more aggressive manner. DM #401 stated mice had been caught in parts of the building during the week of 10/20/25. DM #401 verified the presence of multiple flies and gnats in Resident #14's room and stated that housekeeping should be cleaning the rooms every day to help control them. Interview on 10/22/25 at 12:01 P.M. with the Administrator confirmed there had been a mouse problem in both Resident #14 and Resident #49's rooms. The Administrator revealed that traps were placed in both rooms, and they were sprayed with peppermint oil. The Administrator stated if the problem persisted, the facility would have the pest control vendor complete a more aggressive treatment. Review of the pest control service report dated 09/12/25 revealed a monthly standard service was completed. Further review revealed the outside was inspected and some of the bait stations (used to treat rodents) had bait eaten. The glue boards (non-toxic trays with a strong adhesive to trap and immobilize pests like mice, rats, and insects) were changed in the kitchen. Fly lights (used to attract flies and other insects) were treated, along with all the doors. There were drain flies in the kitchen, and a treatment was completed. Additional review of the open actions from previous service section revealed on 12/13/24, door gaps were noted with a recommendation to add/repair door sweeps on the common area doors; on 01/10/25, a water leak was identified in the kitchen with a recommendation to repair the leak; on 01/10/25, debris was present in the kitchen, with a recommendation to clean the area; on 04/11/25, debris was present in the kitchen, with a recommendation to clean and sanitize the area; and on 08/15/25, overgrown vegetation was noted on the exterior of the building, with a recommendation to cut the vegetation for insect and rodent control. The customer (facility) was identified as the responsible party for the open actions. Review of a Commercial Services Agreement Addendum, dated 10/09/25, revealed the pest control vendor provided an estimate for additional services to treat rats and mice. The scope and nature of the work was rodent repellent service. The agreement was not signed by the facility. Review of the pest control service report dated 10/10/25</p>		