

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 12/01/2025
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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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F 0550 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and policy review, the facility failed to ensure staff honored the rights of residents. This resulted in actual harm on 11/12/25 at 2:50 P.M. when Resident #145 expressed fear of a nurse and a concern for her health status after a nurse unexpectedly approached her and administered a second dose of the influenza vaccination in error, despite Resident #145 declining the shot and informing the nurse that she had already received the 2025 influenza vaccination. This affected one resident (#145) of three residents reviewed for resident rights. The facility census was 67. Review of Resident #145's medical record revealed an admission date of 10/14/25. Diagnoses included cellulitis of the chest wall, type II diabetes mellitus, chronic pulmonary edema, obesity, and post-traumatic stress disorder. Review of Resident #145's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required the use of a wheelchair for mobility. Review of Resident #145's care plan revealed a past history of abuse where the resident was forced to do things against her will. Interventions included to keep the resident informed about changes in care, to provide a quiet non-threatening environment, to decrease stimulation, to reapproach the resident if care is resisted, and staff are not to attempt to force care. Review of the immunization record consent and information sheet revealed Resident #145 declined to receive both the influenza and pneumococcal vaccinations on 10/14/25. The declination was witnessed by Licensed Practical Nurse (LPN) #728. Review of Resident #145's physician orders revealed an order dated 10/14/25 and timed at 2:24 P.M. to administer the annual influenza vaccine unless contraindicated. Review of Resident #145's Medication Administration Record (MAR) for October 2025 revealed the influenza vaccination was administered intramuscularly on 10/15/25 at 4:19 P.M. into Resident #145's right deltoid. Further review of Resident #145's physician orders revealed an order dated 11/12/25 and timed at 10:53 A.M. for the pneumococcal vaccination to be administered intramuscularly one time only for two days. Review of Resident #145's MAR for November 2025 revealed that the pneumococcal immunization was administered on 11/12/25 at 2:50 P.M. into the resident's right deltoid by Registered Nurse (RN) #590. Review of a Medication Error Report written 11/13/25 at 9:50 A.M. revealed a medication error occurred on 11/12/25 at 2:51 P.M. when RN #590 administered an influenza vaccination to Resident #145 on 11/12/25 at 2:50 P.M. instead of the ordered pneumococcal vaccination. Review of the facility investigation completed by Infection Control Preventionist (ICP) LPN #801 of the medication error revealed she had placed the order for the pneumococcal vaccination on 11/12/25 and specifically put the timeline for two days to allow time for the vaccine to arrive from the pharmacy as the pneumococcal vaccination was not available in the facility. Per the investigation, Resident #145 was interviewed and revealed she informed RN #590 that she had previously received the influenza vaccine. Resident #145 stated she refused the vaccination when RN #590 came in the room and offered it to her. Resident #145 stated RN #590 informed her that she nor her husband, who was on the phone per video at the time of the incident, knew what they were talking about, at which time RN #590 came up behind Resident #145 and poked the resident in the right arm with the vaccination. Interview with the Administrator on 11/24/25 at 12:22 P.M. verified RN #590 administered the influenza vaccination to Resident #145 against her will and also verified the medication error occurred when RN #590 administered the influenza vaccination, instead of the pneumococcal vaccination. The Administrator confirmed Resident #145 received two influenza immunizations this season and should not have. Interview with Resident #145 on 12/01/25 at 11:50 P.M. revealed she decided to receive the influenza vaccination in October 2025, and it was administered. Resident #145 voiced concern that the influenza vaccination was administered again and against her will in November 2025. Resident #145 stated on 11/12/25 RN #590 entered her room and informed her she was to receive an influenza vaccination. Resident #145 stated she verbally refused the immunization and informed RN #590 that she previously received the vaccination. RN #590 told Resident #145 that she did not know what she was talking about at which time RN #590 came up behind Resident #145 and injected the immunization into her right arm. Resident #145 said she reported the nurse to administration. Resident #145 stated she is now afraid of RN #590, while the nurse no longer provides her care she is still in the building and provides care to other residents. Resident #145 also voiced concerns for her health due to receiving two influenza vaccinations a month apart. Interview with Certified Nurse Practitioner (CNP) #600 on 12/01/25 at 12:02 P.M. revealed she was aware Resident #145 received two influenza vaccinations. CNP #600 did see Resident #145 after being made aware of the administration of</p>		

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F 0600 Level of Harm - 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)

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEYBased on medical record review, staff interviews, review of the facility incident investigation, review of video surveillance, review of employee personnel files, review of the facility self-reported incident (SRI), and review of facility policy, the facility failed to ensure residents were free from abuse. Actual harm occurred on 11/15/25 at 8:42 P.M. when Resident #169 was subjected to excessive physical force by a facility staff member, after which Resident #169 verbalized a fear for his safety, and being depressed at times with positive thoughts of self-harm. This affected one (#169) of three residents reviewed for abuse. The facility census was 67. Review of the medical record for Resident #169 revealed an admission date of 07/22/25 and discharged date of 11/19/25. Diagnoses included alcohol dependence with withdrawal, anxiety, depression, difficulty walking, tobacco use, type two diabetes mellitus, chronic obstructive pulmonary disease, and noncompliance with other medical treatment. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #169 revealed he was identified as moderately cognitively impaired. Resident #169 was independently mobile with a manual wheelchair and required minimal assistance with bathing, lower body dressing, bed mobility, and transfers, had no aggressive behaviors toward self or others and no refusals of care. Review of a progress note dated 11/15/25 and timed at 8:58 P.M. written by Licensed Practical Nurse (LPN) #800 revealed Resident #169 was observed drinking alcohol in the designated smoking area. When Resident #169 was approached regarding the liquor and beer, the resident became agitated and started swinging at staff threatening them. Review of the physician orders for Resident #169 revealed he did not have an order to consume alcohol. Review of progress notes dated 11/16/25 revealed Resident #169 refused nursing care offered at 12:02 A.M., medications offered at 8:00 A.M., and a post-incident skin assessment attempted at 2:02 P.M. Review of a psychiatric physician note dated 11/17/25 revealed Resident #169 reported an altercation with LPN #800 to the physician. Resident #169 reported feeling depressed at times with positive thoughts of self-harm. Review of a progress note dated 11/17/25 and timed at 8:10 P.M. revealed Resident #169 was placed on a one-to-one observational status. Review on 11/25/25 at 10:45 A.M. and on 12/01/25 at 9:45 A.M. with the Administrator, of a two-minute surveillance video dated 11/15/25 and timestamped at 8:42 P.M. revealed Resident #169 was in the outdoor smoking area with a group of other residents. Resident #169 was observed sitting in his wheelchair wearing an unzipped coat and smoking a cigarette. Resident #169 was holding his cigarette with his right hand. Certified Nurse Assistant (CNA) #605 and CNA #712 were supervising the group of residents in the outdoor smoking area. LPN #800 entered the smoking area and walked toward Resident #169, approached the front of Resident #169, then circled around the resident from the right side, and stopped on the left side of the resident. LPN #800 then reached toward Resident #169 with her right hand, taking hold of the front left side of Resident #169's coat. LPN #800 proceeded to pull open the coat toward the left side of Resident #169's body and with her left hand reached between the coat and Resident #169's left side. Unidentifiable items were seen falling to the ground. Resident #169 pushed at LPN #800 with his left arm and LPN #800 let go of the coat. LPN #800 again reached for Resident #169's coat, this time while holding Resident #169's left arm down, LPN #800 pulled open the coat to the residents' left side and reached inside the coat toward Resident #169's left side. CNA #605 was seen walking toward the resident's right side while LPN #800 was reaching in and around Resident #169's coat and pulling on Resident #169's left arm. LPN #800 let go of Resident #169's left arm and backed away from the resident. Resident #169 was then observed shaking his left arm at LPN #800 while shuffling his feet to move the wheelchair closer to the nurse. LPN #800 took hold of Resident #169's left arm and pulled it away from his body while CNA #605 flicked the cigarette out of Resident #169's right hand onto the ground. LPN #800 moved to Resident #169's right side, took hold of the right side of the coat, pulled it open, reached into the coat toward Resident #169's right side and obtained an open can of an alcoholic beverage. LPN #800 handed the open beverage can to CNA #605 who poured the liquid out in the grassy area behind Resident #169. Resident #169 extended his right arm and index finger toward LPN #800's face. LPN #800 swung at Resident #169's right arm, making contact, knocking Resident #169's arm down. This occurred two additional times before LPN #800 walked away, leaving the outdoor smoking area. Review of the facility investigation interviews dated 11/16/25 with CNA #605 and CNA #712 revealed no deviation in the</p>		