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	03/16/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff interview, the facility failed to ensure a dependent resident received assistance with eating. This affected one (#01) of three residents reviewed for mealtime assistance. The facility census was 61. Findings include:Review of the medical record revealed Resident #01 admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, moderate protein calorie malnutrition, hypertension, pain, osteoarthritis, mixed incontinence, and cerebral ischemia. On 10/18/24 Resident #01 was admitted to hospice services with the diagnosis cerebral atherosclerosis. Review of the nursing plan of care implemented on 10/23/24 addressed Resident #01's activity of daily living performance deficit related to Alzheimer's, confusion, impaired balance, diagnosis of Cerebral Atherosclerosis with life expectancy of six (6) months or less if the disease followed the natural course. Interventions included: Assist with feeding. Required documentation. The resident was totally dependent on two (2) staff for bed mobility. The resident was totally dependent on one (1) staff for personal hygiene and oral care. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was assessed with unclear speech, rarely/never understood, sometimes understands others, severe cognitive impairment, no recorded behaviors, dependent on staff for the provision of activities of daily living including eating, incontinent of bowel and bladder, weight of 62.0 pounds, on a physician prescribed weight gain regimen, received a mechanically altered therapeutic diet, and was at risk for pressure ulcer development with no skin breakdown. Review of the current physician orders revealed Resident #01 had the following orders; 06/02/25 a magic cup (a supplement) three times a day with lunch and dinner, 10/27/25 a regular diet, dysphasia advanced texture with thin liquid consistency, 01/30/26 monthly weights as tolerated. Review of the nutritional plan of care dated 09/12/25 and revised on 03/10/26 was implemented due to Resident #01's nutritional problem or potential nutritional problem related to underweight for age. Interventions included: provide and serve supplements as ordered, provide and serve diet as ordered, monitor intake and record every meal, and weigh as tolerated by the resident. Review of Resident #01's monthly weight record noted the following; on 03/04/26 the resident weighed 62.4 pounds, on 02/05/26 the resident weighed 62.4 pounds, on 01/19/26 the resident weighed 59.1 pounds, and on 01/05/26 the resident weighed 58.8 pounds. Review of the Nutritional Risk assessment dated [DATE] revealed Resident #01 had a recorded weight of 62.4 pounds and Body Mass Index (BMI) of 11.8 noting under weight for height and age. Intakes remain variable to poor. Ordered magic cup three times daily in addition to the house supplement eight (8) ounces three times daily. These were offered for comfort as opposed to aggressive nutrition interventions. No additional recommendations. Resident #01 had no weight or intake goals due to on hospice. As a hospice resident comfort should be maintained. Weigh resident as tolerated by resident. Offer supplements per her comfort/tolerance. Continue care plan as ordered; will continue to monitor and follow up as needed. Review of a functional abilities assessment dated [DATE] scored Resident #01 as dependent with activities of daily living including eating. During a continuous observation on 03/16/26 between 7:52 A.M. and 8:49 A.M., revealed at 7:52 A.M., the Certified Nursing Assistant (CNA) #200 took a breakfast tray into Resident #01's room, placed the tray on the overbed table, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elevated the head of the bed, uncovered the plate and the bowl of hot cereal. CNA #200 proceeded to cut-up the food on the plate, set-up the meal in front of Resident #01 and opened a single use cardboard milk container. CNA #200 obtained a packet of sugar and placed the sugar on the hot cereal in the bowl and placed a spoon in the bowl. CNA #200 then left the room. Resident #01 was observed looking toward the television. At 7:57 A.M., Resident #01 had her eyes closed with no attempts to feed herself. At 8:05 A.M., Resident #01 remained in bed with no attempts to feed self, and food remained uncovered. At 8:10 A.M., Resident #01 was noted to obtain the carton of milk and attempted to drink. CNA #200 was observed seated at a computer in the 400 unit lounge. At 8:22 A.M. Resident #01 continued to attempt drinking from the milk carton with no attempts to eat the food. CNA #200 remained seated at the computer. At 8:31 A.M. Resident #01 continued with attempts to drink from the milk container. No attempts to take bites of food. At 8:36 A.M. Program Coordinator #300 went into the room and asked Resident #01 how breakfast was providing Resident #01 no assistance with the meal and left the room at 8:36 A.M. At 8:46 A.M. Resident #01 remained in bed holding the milk carton with no attempts to eat. At 8:49 A.M. CNA #200 went to the room and asked Resident #01 if she was finished. No verbal response was observed from Resident #01. CNA #200 placed the lid on the plate of untouched food and removed the tray from the room. During an interview on 03/16/26 at 8:52 A.M., CNA #200 verified Resident #01 had not eaten any of the breakfast meal. Observation on 03/16/26 at 12:09 P.M., CNA #200 took a meal tray to Resident #01's room and placed the tray in front of the resident on an overbed table. CNA #200 repositioned Resident #01 in bed and proceeded to uncover and set-up the lunch meal. CNA #200 sat next to Resident #01 and instructed Resident #01 to take a bite of each item before refusing the entire meal providing Resident #01 with bites of food from a spoon. At 12:17 P.M., the CNA #200 informed Registered Nurse (RN) #400 Resident #01 consumed a half portion of ice cream and a bite of beans while removing the tray from Resident #01's room. CNA #200 left the remaining portion of ice cream on the overbed table. However, no offer was provided to Resident #01 regarding meal alternatives. During a follow-up interview on 03/16/26 at 12:19 P.M., CNA #200 verified they had not offered to assist Resident #01 with breakfast. In addition, no attempts were initiated to offer alternative food choices following the lunch meal. During an interview on 03/16/26 at 12:28 P.M., RN #400 verified Resident #01 was dependent on staff for eating and was not provided with assistance during the breakfast meal. Additionally, Resident #01 was not offered alternative food choices when refusing the lunch meal. This deficiency represents non-compliance investigated under Complaint Number 2801593. This deficiency represents continued non-compliance from the biannual and complaint surveys completed on 03/05/26.