STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366125	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Shane Hill	10731 State Route 118 Rockford, OH 45882

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on review of the facility's Self-Reported Incidents (SRI), facility investigation documentation, staff interview, and review of facility policy, the facility failed to ensure staff were immediately removed from the floor when allegations of staff to resident verbal abuse occurred. This affected one resident (#5) of four residents reviewed. The facility census was 65. Findings Include: Review of Resident #5's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included major depressive disorder, altered mental status, type II diabetes, anxiety disorder, chronic pain, and insomnia. Review of Resident #5's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #5 was cognitively intact. Resident #5 required supervision with toilet use and personal hygiene. Resident #5 was independent with dressing, transfer and mobility. Resident #5 required maximal assistance with bathing. Resident #5 displayed no behaviors at the time of the review. Review of Resident #5's care plan canceled 02/28/25 revealed supports and interventions for self-care deficit, anemia, pain, diabetes, and depression. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER: Divine Rehabilitation and Nursing at Shane Hill		STREET ADDRESS, CITY, STATE, ZIP CODE: 10731 State Route 118 Rockford, OH 45882	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Self-Reported Incident (SRI) 255532 revealed on 12/27/24 staff witnesses reported Certified Nursing Assistant (CNA) #499 was frustrated and argumentative with Resident #5. Review of the investigation documentation found on 12/27/24 at approximately 5:00 P.M. Resident #5 was seated in the dinning room, got up and went back to her room to get her dentures. Resident #5 was still in her room when her dinner tray came out of the kitchen and CNA #499 took Resident #5's dinner tray down to her room. Resident #5 was reported to have been cussing and yelling at CNA #499. CNA #499 was observed coming out of Resident #5's room with a raised voice saying Resident #5 was not going cuss at her when she was doing what she was told to do. She proceeded to drop Resident #5's dinner tray on the nurses station counter. CNA #499 was directed by Registered Nurse (RN) #572 to place the tray back at Resident #5's seat in the dining room. CNA #499 complied and was overheard continuing to yell and argue with Resident #5. It was noted CNA #499 grabbed her coat and went out to take a smoke break. CNA #499 commented she was getting agitated and it was what she was told to do. CNA #499 was noted to have stayed out of the building for about 20 minutes before returning to the floor. In CNA #499's statement she indicated she came back into the facility and spoke with another unidentified staff about getting through the night and it would get better. At 6:38 P.M. the Director of Nursing (DON) received a phone call about the situation and advised RN #572 to have CNA #499 to go home. At approximately 7:07 P.M. Licensed Practical Nurse (LPN) #548 told CNA #499 the DON wanted her to leave the building that night and to call in on Monday. At 7:15 P.M. CNA #499 clocked out. CNA #499 sent a text on 12/27/24 at 7:19 P.M. to the DON for confirmation she was to leave the building and reported she had already clocked out. The concern for staff to resident verbal abuse began on 12/27/24 at approximately 5:00 P.M. and CNA #499 continued to work in the facility until 7:15 P.M. when she clocked out. CNA #499 remained in the facility for approximately two hours after the concern arose. Interview on 03/14/25 at 12:54 P.M. with the Director of Nursing (DON) and the Administrator verified the verbal altercation began between CNA #499 and Resident #5 at approximately 5:00 P.M. and CNA #499 remained in the facility until 7:15 P.M. when she clocked out. Review of the facility policy titled, Abuse, Neglect, and Exploitation, revised August 2024 revealed the facility would make efforts to ensure all residents were protected from physical and psychosocial harm as well as additional abuse during and after the investigation. The staff were to respond immediately to protect the alleged victim.