

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 06/04/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, review of facility Self-Reported Incident (SRI), staff interview and policy review, the facility failed to ensure residents were free from abuse and neglect. This affected one (#10) of three residents reviewed for abuse. The facility census was 64.</p> <p>Findings include:</p> <p>Review of medical record for Resident #10 revealed an admission date of 08/22/22 diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety major depressive disorder, single episode, unspecified, other cerebrovascular disease.</p> <p>Review of Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental status (BIMS) score of 13 indicating intact cognition. She was independent for eating, was dependent for toileting and required maximum assistance for bed mobility and transfers.</p> <p>Review of Resident #10's progress note dated 05/04/25 at 7:15 P.M. revealed the resident was heard yelling from her room and found lying beside her bed. There was no further documentation regarding the incident.</p> <p>(continued on next page)</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/04/25 at 3:10 P.M. with the Administrator and Director of Nursing (DON) revealed it was brought to their attention on 05/08/25 that Certified Nursing Assistant (CNA) #50 had witnessed the abuse of Resident #10 by CNA #51 and Licensed Practical Nurse (LPN) #52 on 05/04/25. CNA #50 had informed management during her training by CNA #51 they entered Resident #10's room and CNA #51 informed Resident #10 she was going to put her in an incontinence product, and she should urinate in it and they would be back to check and change her. The DON explained Resident #10 was able to call staff when needed and ambulate to the bathroom and did not require an incontinence product routinely. The DON explained when she questioned CNA #50, she was informed due to previous experiences at reporting incidents at her previous employer, CNA #50 did not believe her concerns would be addressed and she feared the retribution she experienced there. During the interview, the Administrator shared CNA #50 also informed them after Resident #10 had fallen on 05/04/25, LPN #52 had instructed CNA #50 and #51 to assist her off the floor and onto the bed. CNA #50 stated Resident #10 began to yell when she was moved, and LPN #52 placed her hand on the mouth of Resident #10 and asked her to be quiet. Both staff members were removed from the schedule pending the investigation. The Administrator revealed she reviewed camera footage from 7:00 P.M. to 12:00 A.M. on 05/04/25 which showed LPN #52 went into Resident #10's room for 13 seconds around the time of her fall and then exited the room. The Administrator stated LPN #52 did not return to the room until the 8:00 P.M. with medication pass, when she was in the room for about 36 seconds. The Administrator stated during her investigation she interviewed both CNA #51 and LPN #52 who verified the allegation involving Resident #10 were accurate and each were terminated.</p> <p>Interview on 06/04/25 at 3:33 P.M. with CNA #50 revealed Resident #10 was able to use her call light, was able to inform staff when she needed to use the bathroom and was able to ambulate with assistance from staff. CNA #50 shared CNA #51 placed an incontinent product on Resident #10 because she did not want to toilet her frequently, and informed Resident #10 she would be in to check and change her later throughout the shift. CNA #50 stated a short time later into the shift, they found Resident #10 on the floor beside her bed. LPN #52 was notified and came into the room when she instructed CNA #50 and #51 to assist Resident #10 up and back into her bed. CNA #50 stated Resident #10 began to yell when they moved her, and LPN #52 put her hand over Resident #10's mouth to quiet her. CNA #50 shared she did not report her concern to management and explained at the facility previously worked at would not investigate concerns she had brought to management's attention, and she felt there was retribution for reporting issues. CNA #50 stated when she reported the concern to the scheduler why she no longer wanted to work at the facility; she was contacted by management and an investigation was initiated. CNA #50 stated she did receive education regarding the timeliness of reporting abuse and denied she had any further concern for the care and or treatment of residents at the facility.</p> <p>Review of a facility SRI dated 05/09/25 titled Neglect/Mistreatment Abuse revealed it was reported that Resident #10 had a fall and the LPN #52 did not assess her before they got her off the floor. It was also reported that LPN #52 put her hand over Resident #10's mouth because she was yelling out. It was also reported that CNA #51 told Resident #10 she was putting a brief on her stating we are not doing this. The SRI did not indicate the day the allegation occurred. The allegation was investigated by the facility and substantiated.</p> <p>Review of the typed statement of the DON revealed she interviewed LPN #52 who verified she did not do an assessment of Resident #10 prior to instructing CNA's #50 and #51 to assist her back to bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the electronic mail statement from CNA #51 documented on 05/04/25 Resident #10 had fallen and the nurse instructed CNA #50 and #51 to assist Resident #10 back to bed without an assessment or taking vitals.</p> <p>Review of the facility provided termination document for CNA #51 revealed a violation of putting an incontinence product on Resident #10 in order not to toilet her frequently. This was signed by CNA #51 on 05/12/25.</p> <p>Review of the electronic mail statement from LPN #52 revealed after Resident #10 had fallen, she began to yell as staff assisted her from the floor. LPN #52 put her hand up to Resident #10's mouth and asked her to please stop yelling.</p> <p>Review of the facility provided termination document for LPN #52 revealed a violation which included a violation of abuse policy. This was signed by LPN #52 on 05/12/25.</p> <p>Review of the facilities undated policy titled Abuse, Neglect and Exploitation revealed it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy further indicated alleged violations would be reported to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>As a result of the incident, the facility took the following actions to correct the deficient practice by 05/12/25:</p> <ul style="list-style-type: none"> &bull; On 05/09/25, the facility submitted an SRI and began an investigation into the allegation involving Resident #10. &bull; CNA #51 and LPN #52 were terminated by the facility on 05/12/25. &bull; All staff received education on the abuse policy including the timeliness of reporting concerns was completed by 05/12/25. The education was completed by the Administrator or designee. &bull; The facility conducted ongoing monitoring and there were no further abuse concerns. &bull; <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interviews on 06/04/25 with LPN #45, LPN #46, CNA #40, CNA #48, CNA #49 and CNA #50 reported they had received training on abuse and timeliness of reporting.</p> <p>&bull;</p> <p>Interview of Resident #10 on 06/04/25 revealed she did not have a concern for her safety at the facility.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165736.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, review of facility Self-Reported Incident (SRI), staff interview and policy review, the facility failed to ensure allegations of abuse and neglect were timely reported to the Administrator. This affected one (#10) of three residents reviewed for abuse. The facility census was 64.</p> <p>Findings include:</p> <p>Review of medical record for Resident #10 revealed an admission date of 08/22/22 diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety major depressive disorder, single episode, unspecified, other cerebrovascular disease.</p> <p>Review of Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental status (BIMS) score of 13 indicating intact cognition. She was independent for eating, was dependent for toileting and required maximum assistance for bed mobility and transfers.</p> <p>Review of Resident #10's progress note dated 05/04/25 at 7:15 P.M. revealed the resident was heard yelling from her room and found lying beside her bed. There was no further documentation regarding the incident.</p> <p>Interview on 06/11/25 at 3:10 P.M. with the Administrator and Director of Nursing (DON) revealed it was brought to their attention on 05/08/25 that Certified Nursing Assistant (CNA) #50 had reported an allegation of the abuse of Resident #10 by CNA #51 and Licensed Practical Nurse (LPN) #52 which occurred on 05/04/25. CNA #50 had informed management during her training by CNA #51 they entered Resident #10's room and CNA #51 informed Resident #10 she was going to put her in an incontinence product, and she should urinate in it and they would be back to change her later in the shift. The DON explained Resident #10 was able to call staff and ambulate to the bathroom. The DON explained when she questioned CNA #50, she was informed due to previous experiences at reporting incidents at her previous employer, CNA #50 did not believe her concerns would be addressed and she feared the same retribution she experienced there.</p> <p>(continued on next page)</p>		

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