

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/11/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to ensure safe temperatures were maintained and documented for resident personal refrigerators. This deficient practice affected four (#7, #37, #38, and #40) of four residents reviewed for personal refrigerators. The facility census was 54. Findings include: Observation on 06/08/26 at 9:50 A.M. revealed Resident #37 had a personal refrigerator with soda and bologna inside. The refrigerator had no thermometer or documented monitoring of temperatures. Observation on 06/08/26 at 10:00 A.M. revealed Resident #7 had a personal refrigerator with nutritional shakes, soda, cheese, energy drink, and candy inside. The refrigerator had no thermometer or documented monitoring of temperatures. Observation on 06/08/26 at 10:16 A.M. revealed Resident #38 had a personal refrigerator with soda inside. The refrigerator had no thermometer or documented monitoring of temperatures. Observation on 06/08/26 at 10:24 A.M. revealed Resident #40 had a personal refrigerator with soda inside. The refrigerator had no thermometer or documented monitoring of temperatures. Interview on 06/08/26 at 10:01 A.M. with Laundry Aid #37 revealed there was no recorded refrigerator temperature monitoring for Resident #7, #37, #38, and #40, and no thermometers to monitor the temperature for Resident #37, #38, and #40. Review of the undated facility policy titled, Resident Refrigerators, revealed maintenance staff shall record refrigerator temperature weekly on a temperature log attached to the refrigerator. A thermometer shall remain in the refrigerator.		

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 - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and resident representative interview, staff interview, and review of posted meal times, the facility failed to serve meals in a manner to preserve resident dignity. This affected two (#45 and #10) of two residents directly observed during meals. The facility census was 54. Findings include: 1. Observation on 06/08/26 at 12:30 P.M. revealed 14 residents seated in the dining room at seven tables. Two residents were assisted to eat by two staff members at one table. Two tables had one resident seated at a table with two additional residents which had food and were eating while the other two residents waited. Two tables had one resident seated at the table with one additional resident who had food and was eating while the other resident waited. Three tables had only one resident at the table. The additional residents, seated at tables with those already served, were served their meals sporadically. The last resident (#45) served was seated at a table with two additional residents who both had their food and were eating for five minutes prior to the last meal served. Review of the medical record of Resident #45 revealed an admission date of 12/55/23 with diagnoses including depression and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 was cognitively intact. Interview on 06/08/26 at 12:47 P.M. with Resident #45 revealed she did not enjoy sitting at the table and waiting on her food while the other two ate their food and it happened regularly. Interview on 06/08/26 at 12:50 P.M. with Certified Nurse Aide (CNA) #55 verified the residents were not served in a dignified manner stating, It would be better if all at the table were served simultaneously. 2. Review of the medical record for Resident #10 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #10 include Alzheimer's disease, dementia with agitation, macular degeneration, heart disease, and thrombocytopenia. Review of the MDS assessment dated [DATE] revealed Resident #10 had impaired cognition and had no issues with swallowing or nutritional status. Review of the posted meal times revealed for the 100 hall (Memory Care Unit) the meal trays were to be served at 12:00 P.M. Interview on 06/08/26 at 12:40 P.M. with Resident #10's family representative revealed the resident no longer liked eating in the dining room due to the cleanliness and condition of the dining room itself. Per the family representative, Resident #10 now ate in her room which delayed the delivery of her food trays. Per the family representative, the scheduled lunch meal should start being served by 12:00 P.M. per the posted time, but stated the meals are always late and usually are not served until after 12:15 P.M. to 12:30 P.M. Observation on 06/08/26 at 12:47 P.M. Resident #10's meal tray was brought into the resident's room. Interview on 06/11/26 at 8:45 A.M. with Licensed Practical Nurse (LPN) #28 verified the meal service was always served after the posted times. LPN #28 verified there have been residents and family complaints regarding the late meal service. LPN #28 stated the lunch meal trays are always served after 12:15 P.M. Observation and interview on 06/11/26 from 11:50 A.M. to 12:45 P.M. of the lunch meal service in the kitchen revealed at 12:15 P.M. the trays for the Memory Care Unit were transported out of the kitchen. Observation at 12:20 P.M. revealed CNA #16 was the only staff member on the unit delivering food trays. CNA #16 verified the meal trays were delivered to the unit 15 minutes after the posted time of 12:00 P.M. which caused a delay for all 20 residents on the unit receiving their meals. CNA #16 stated the residents on the locked unit usually gather in the dining room [ROOM NUMBER] to 15 minutes before 12:00 P.M. to wait for their meals.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, family representative interview, staff interview, and facility policy review, the facility failed to maintain the building in a safe, clean, and homelike manner. This affected two (#10 and #48) of 20 residents residing on the Memory Care Unit. The census was 54. Findings Include: Observation on 06/08/26 at 9:30 A.M. during tour of the Memory Care Unit dining room revealed, on the East wall, an air conditioning (AC) unit was installed in the wall under a window. Around the AC unit and along the wall near the floor there appeared to be three large black-green fuzzy spots on the wall. On the North wall, the wallpaper located next to the door leading into the kitchen area was torn and peeling off the wall in four spots. There appeared to be brown residue on the floor where the wall connected to the flooring under the torn wallpaper. On the North wall of the dining room there was a counter with a kitchen-style sink, and under the sink there were brown-red stains observed with a pervasive odor noted. Observation on 06/08/26 at 9:40 A.M. of the Memory Care Unit dining room floor revealed, along the South wall from the [NAME] to East wall, there were missing or broken tiles with what appeared to be sharp edges. Observation on 06/08/26 from approximately 9:40 A.M. to 10:00 A.M., Resident #48 was observed taking off his socks and walking barefoot around the dining room in the Memory Care Unit. Resident #48 appeared confused, was talking to himself, and appeared to be visual hallucinating. Resident #48 was observed walking on the broken tiles and around the dining room areas including the area of the AC unit by the window on the East wall. Interview on 06/08/26 at 10:02 A.M. with Certified Nurse Aide (CNA) #18 verified there were broken and missing tiles on the dining room floor. CNA #18 verified Resident #48 would take off his socks and ambulate independently around the dining room in his bare feet at times. CNA #18 verified the condition of the wall with the AC unit, the spill under the sink, the peeling wallpaper, and overall unsanitary condition of the dining room area. CNA #18 stated staff have reported the concerns to the maintenance department and were waiting for repairs. Interview on 06/08/26 at 12:47 P.M. with Resident #10's family representative revealed the resident no longer liked eating in the dining room due to the cleanliness and condition of the dining room itself. Per the family representative, the dining room was in disrepair and it was, Too gross to eat in. Interview on 06/08/26 at 12:33 P.M. with Regional Maintenance Director (RMD) #76 and Maintenance Tech (MT) #44, during a tour of the Memory Care Unit dining room, verified the three large black-green fuzzy spots on the wall and the North wall wallpaper located next to the door leading into the kitchen area was torn and peeling off the wall in three to four spots. RMD #76 verified there were missing and broken tiles all along the East wall of the dining room. Review of the facility policy titled, Homelike Environment, dated 2025, revealed the facility will provide a clean, safe, and comfortable homelike environment. Review of the undated facility policy titled, Dining and Resident Activity Rooms, revealed the facility will provide a room designated for resident dining which is safe, functional, and sanitary. This deficiency represents non-compliance investigated under Complaint Number 3034522.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed when a resident was diagnosed with a new serious mental illness. This deficient practice affected one (#7) of one residents reviewed for PASARR. The facility census was 54. Findings include: Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses including cerebral palsy, schizoaffective disorder, bipolar type, type two diabetes mellitus, neuromuscular dysfunction of bladder and conversion disorder with seizures. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident was assessed to be dependent on oral hygiene, toileting, bathing, and dressing. Resident #7 took antipsychotic, antidepressant, opioid, insulin, and anticonvulsant medications during the assessment look-back period. Review of Resident #7's medical record revealed the resident had schizoaffective disorder added as a new diagnosis in April 2024. No PASARR was completed at time of the new diagnosis. Interview on 06/08/26 at 3:45 P.M. with the Director of Nursing (DON) verified no PASARR was completed after Resident #7 was diagnosed with schizoaffective disorder in April 2024.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were not pre-prepared for administration. This affected three (#48, #52, and #55) of three residents observed with medications which were pre-prepared and not given immediately after preparation. The facility census was 54. Findings include: Observation and interview on 06/10/26 at 8:05 A.M. revealed a medication cart in the locked room of the 100 Hall. A small plastic cup containing five opened tablets/capsules was on the top of the cart. Licensed Practical Nurse (LPN) #65 removed the cup, opened a drawer, and placed the cup in a small cubby. LPN #65 identified the medications as ready to be administered to Resident #52. Once the drawer was opened, two additional small plastic cups were in the drawer with opened medications. One cup contained crushed medications, identified by LPN #65 as ready to be administered to Resident #48, and the other contained 10 tablets/capsules, identified by LPN #65 as ready to be administered to Resident #55. Review of the medical record of Resident #48 revealed the medication administration record (MAR) indicated medications to be administered at 8:00 A.M. on 06/10/26 included aspirin 81 milligrams (mg) one tablet, Lasix 20 mg one tablet, lisinopril 20 mg one tablet, potassium chloride 10 milliequivalents (mEq) one tablet, sertraline 50 mg one tablet, Depakote sprinkles 125 mg two capsules, and acetaminophen extra strength 500 mg two tablets. Review of the medical record of Resident #52 revealed the MAR indicated medications to be administered at 8:00 A.M. on 06/10/26 included sertraline 100 mg two tablets, and Depakote sprinkles 125 mg four capsules and hydroxyzine pamoate 50 mg one capsule to be administered at 10:00 A.M. Review of the medical record of Resident #55 revealed the MAR indicated medications were to be administered at 8:00 A.M. on 06/10/26 included ferrous sulfate 325 mg one tablet, Flomax 0.4 mg one capsule, loratadine 10 mg one tablet, losartan 50 mg one tablet, sitagliptin 50 mg one tablet, clozapine 100 mg three tablets, nabumetone 500 mg one tablet, and ziprasidone 60 mg on capsule. Review of the undated policy titled, Medication Administration, revealed medications are to be administered in accordance with professional standards of practice.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of medication packaging, and policy review, the facility failed to ensure medications were administered as ordered resulting in a medication error rate greater than five (5) percent (%). A total of two (2) medication errors were observed out of 29 opportunities for a medication error rate of 6.9%. This affected two (#22 and #40) of four residents observed for medication administration. The facility census was 54. Findings include: 1. Review of the medical record of Resident #22 revealed an admission date of 04/08/26. Diagnoses included dementia, anxiety, and chronic obstructive pulmonary disease. Review of the physician order dated 06/01/26 revealed Resident #22 was ordered fluticasone propionate nasal suspension 50 micrograms per activation (mcg/act) with instructions for one spray in both nostrils one time a day for seasonal rhinitis. Observation on 06/10/26 at 8:05 A.M. revealed Licensed Practical Nurse (LPN) #65 handed Resident #22 the bottle of fluticasone propionate nasal suspension 50 mcg/act. Resident #65 sprayed twice in each nostril and handed the bottle back to LPN #65. LPN #65 had not instructed Resident #22 to spray once in each nostril. Interview on 06/10/26 at 8:10 A.M. with LPN #65 provided verification he had not instructed Resident #22 to only spray once in each nostril per the physician order. 2. Review of the medical record of Resident #40 revealed an admission date of 07/14/22. Diagnoses included chronic obstructive pulmonary disease, chronic diastolic heart disease, and blindness category five. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively intact. Review of the physician order dated 09/10/25 revealed Resident #40 was ordered Trelegy Ellipta inhalation aerosol powder breath activated 100-62.5-25 mcg/act with instructions for one inhalation orally one time a day related to chronic obstructive pulmonary disease and to rinse the mouth with water after use. Observation and interview on 06/10/26 at 8:20 A.M. revealed LPN #33 handed Resident #40 the Trelegy Ellipta inhalation aerosol powder breath activated 100-62.5-25 mcg/act and Resident #40 inhaled once from the device. LPN #33 then left the room and had not instructed Resident #40 to rinse her mouth after the device use. This surveyor questioned LPN #33 on why the nurse had not instructed the resident to her mouth and she stated, She will rinse; she always does. LPN #33 then re-entered Resident #40's room and asked if she had rinsed to which Resident #40 replied, Why? Observation of the Trelegy Ellipta package box revealed the last step in the instructions on the back of the box included, Rinse your mouth after use. Review of the undated policy titled, Administration of Metered-Dose Inhaler, revealed for staff to allow the resident to rinse and gargle with water to remove medication from the mouth and back of the throat.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of a facility sign, the facility failed to ensure staff followed required infection control practices related to care of residents on enhanced barrier precautions. This deficient practice affected one (#4) of four residents reviewed for infection control. The facility census was 54. Findings include: Record review for Resident #4 revealed the resident was admitted to the facility on [DATE] with diagnoses included sequelae of cerebrovascular disease, dysphagia, flaccid neuropathic bladder, and nontraumatic subarachnoid hemorrhage. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #4 had impaired cognition and was assessed to be dependent with all activities of daily living (ADLs). Review of the care plan dated 05/18/26 revealed Resident #4 was on enhanced barrier precautions (EBP) related to a gastrostomy tube (g-tube) site. Observation and interview on 06/08/26 at 1:33 P.M. of Resident #4 revealed Registered Nurse (RN) #24 was administering medication through the resident's g-tube without wearing a gown or gloves for EBP. RN #24 verified at the time of the observation she was not wearing the required personal protective equipment (PPE) for residents on EBP. Review of an undated facility sign for EBP revealed providers and staff must wear gloves and a gown for high-contact resident care, such as a feeding tube.		