STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365022	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Nursing and Rehabilitation	1301 North Monroe Drive Xenia, OH 45385

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, review of witness statements, review of Self-Reported Incidents (SRI), and policy review, the facility failed to implement their abuse policy with an allegation of sexual abuse. This affected one (Resident #06) out of two residents reviewed for abuse. The facility census was 18. Findings include: Review of Resident #06's chart revealed Resident #49 admitted to the facility on [DATE]. Diagnosis included type two diabetes mellitus, major depressive disorder, generalized anxiety disorder, acquired absence of right leg above the knee, peripheral vascular disease, essential hypertension, dementia in other diseases classified elsewhere unspecified severity with agitation, obesity, and Duchenne or [NAME] muscular dystrophy. Review of Resident #06's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of the facility's self-reported incidents (SRIs) from 08/01/25 to 12/07/25, revealed the facility had not reported any allegations of sexual abuse or Resident #12's allegedly showing Resident #06 her breasts, Resident #12 attempting to kiss Resident #06 or Resident #12 calling Resident #06 unwanted names. Observation of Resident #06 on 12/08/25 at 2:06 P.M. revealed Resident #06 was sitting in his electric wheelchair. Resident #06 appeared clean and dressed appropriately. Interview with Resident #06 at the same time, revealed Resident #12 showed him her breasts and called him baby boo and honey. Resident #06 stated that Resident #12 tried to kiss his hand and his cheek. Resident #06 reported he was uncomfortable with Resident #12 showing him her breasts, trying to kiss him or calling him names and did not like Resident #12 making advances towards him. Resident #06 stated he told the facility staff but Resident #12 continued to make sexual advances towards him. Interview with the Administrator on 12/08/25 at 2:17 P.M., revealed the Administrator was not aware of Resident #12's allegedly showing Resident #06 her breasts or Resident #12 attempting to kiss Resident #06. The Administrator stated she was aware that Resident #12 called other residents boo. The Administrator verified the facility failed to implement their abuse policy once the allegations of sexual abuse were discovered. Interview with Certified Nursing Assistant (CNA) #35 on 12/08/25 4:33 P.M., revealed Resident #06 told her that Resident #12 rolled up to Resident #06, lifted her shirt and said, do you like what you see. CNA #35 stated she was not present on the date of the incident but Resident #06 told her about the incident when she came back to work on her next shift about one month ago. CNA #35 stated she did not report the incident because Administration already was aware of the incident and Resident #06 moved when Resident #12 approached him. Interview with Registered Nurse (RN) #600 on 12/08/25 at 4:34 P.M., revealed RN #600 heard about Resident #12 showing Resident #06 her breasts from other staff members approximately one month ago. RN #600 stated she did not report the incident because Administration was already aware. Interview with CNA #24 on 12/08/25 at 4:35 P.M., revealed CNA #24 heard about Resident #12 showing Resident #06 her breasts from other staff members approximately one month ago. CNA #24 stated she did not report the incident because Administration was already aware. CNA #24 stated staff had been trying to keep Resident #06 and Resident #12 separated. Review of the Administrator's written witness statement dated 12/09/25, revealed the Administrator spoke with Resident #06 in regard to another resident allegedly showing him her breasts. When questioned, Resident #06 stated that the incident happened (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a month ago. The Administrator asked if he had actually seen her breasts and Resident #06 stated no and said that he only saw her sports bra. The Administrator asked if he tried to stay away from residents and Resident #06 responded yes and he will move away from her when they are in the common area. Review of the Administrator's written witness statement dated 12/09/25, revealed the Administrator spoke with Resident #12 regarding Resident #12 allegedly exposing her breast. Resident #12 was very tearful and denied the allegation. Resident #12 stated she kept items in her bra like chapstick so she always had her hand in there, but she has never exposed herself. Review of AA #55's written witness statement dated 12/09/25, revealed AA #55 was doing activities visits about one month ago. When AA #55 went into Resident #06's room, Resident #06 started to talk to AA #55 about Resident #12 flashing him. AA #55 asked him if he had seen her breasts and Resident #06 told AA #55 no. Resident #06 stated that she pulled down her jumpsuit that she had on and he saw her sports bra. Review of AA #56's written witness statement dated 12/09/25, revealed AA #56 went in Resident #06's room for activities and Resident #06 started telling her that another resident had shown him her sports bra approximately one month ago when the incident happened. Nothing was ever said to AA #56 from the resident about any other exposure of the body parts until later after he spoke with the DON. Resident #06's story started changing after that to full exposure. Interview with RN #27 on 12/10/2025 at 10:58 A.M., revealed RN #27 was not at the facility on the day of the incident, but she heard about Resident #12 showing Resident #06 her breasts in report about three to four weeks ago. RN #27 stated she did not report the incident because Administration also received report of the incident. Interview with Resident #12 on 12/10/25 at 2:21 P.M., revealed the resident denied showing Resident #06 her breasts. Resident #12 denied kissing or attempting to kiss Resident #06. Resident #12 stated that she called all the residents and staff boo because she could not remember other individual's needs due to her medical condition. Resident #12 stated she liked Resident #06 as a friend and had never made any sexual advances towards him. Interview with the Director of Nursing (DON) on 12/10/25 at 2:34 P.M., revealed the DON was not aware of Resident #12's allegedly showing Resident #06 her breasts or Resident #12 attempting to kiss Resident #06 prior to the surveyor notifying the Administrator of the alleged incident on 12/08/25. Interview with Activities Aide (AA) #56 on 12/10/25 at 2:41 P.M., revealed AA #56 went into Resident #06's room to do activities with him approximately one month ago and Resident #06 told AA #56 that Resident #12 showed Resident #06 her sports bra. AA #56 stated that she saw Resident #06 talking to the DON on that date. AA #56 reported she saw Resident #06 again after Resident #06 talked to the DON and he stated that Resident #12 showed him her breasts. AA #56 stated she told the DON when she heard that Resident #12 exposed her sports bra to Resident #06 and again when Resident #06's allegation changed to Resident #12 showing Resident #06 her breasts. AA #56 reported Resident #06 and Resident #12 were not left alone after the incident, and it was common for Resident #12 to call all the residents and staff boo. AA #56 stated that she had never seen Resident #12 expose herself but stated that Resident #12 kept items in her sports bra for storage. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with RN #27 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with RN #600 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with CNA #33 and CNA #24 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. The DON also spoke with CNA #24 who stated Resident #06 told her that Resident #12 flashed him a long time ago. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation of Resident Property policy dated 01/27/23 revealed the facility will investigate all alleged violations involving abuse. Staff should report allegations immediately to the Administrator or designee. The (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator or their designee will notify the state agency of all alleged violations involving abuse as soon as possible but no later than 24 hours.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, review of witness statements, review of Self-Reported Incidents (SRI), and policy review, the facility failed to report an allegation of sexual abuse to the state survey agency in a timely manner. This affected one (Resident #06) out of two residents reviewed for abuse. The facility census was 18.Findings include: Review of Resident #06's chart revealed Resident #49 admitted to the facility on [DATE]. Diagnosis included type two diabetes mellitus, major depressive disorder, generalized anxiety disorder, acquired absence of right leg above the knee, peripheral vascular disease, essential hypertension, dementia in other diseases classified elsewhere unspecified severity with agitation, obesity, and Duchenne or [NAME] muscular dystrophy. Review of Resident #06's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of the facility's self-reported incidents (SRIs) from 08/01/25 to 12/07/25, revealed the facility had not reported any allegations of sexual abuse or Resident #12's allegedly showing Resident #06 her breasts, Resident #12 attempting to kiss Resident #06 or Resident #12 calling Resident #06 unwanted names. Observation of Resident #06 on 12/08/25 at 2:06 P.M. revealed Resident #06 was sitting in his electric wheelchair. Resident #06 appeared clean and dressed appropriately. Interview with Resident #06 at the same time, revealed Resident #12 showed him her breasts and called him baby boo and honey. Resident #06 stated that Resident #12 tried to kiss his hand and his cheek. Resident #06 reported he was uncomfortable with Resident #12 showing him her breasts, trying to kiss him or calling him names and did not like Resident #12 making advances towards him. Resident #06 stated he told the facility staff but Resident #12 continued to make sexual advances towards him. Interview with the Administrator on 12/08/25 at 2:17 P.M., revealed the Administrator was not aware of Resident #12's allegedly showing Resident #06 her breasts or Resident #12 attempting to kiss Resident #06. The Administrator stated she was aware that Resident #12 called other residents boo. The Administrator verified the facility did not report the allegation of sexual abuse to the state survey agency in a timely manner. Interview with Certified Nursing Assistant (CNA) #35 on 12/08/25 4:33 P.M., revealed Resident #06 told her that Resident #12 rolled up to Resident #06, lifted her shirt and said, do you like what you see. CNA #35 stated she was not present on the date of the incident but Resident #06 told her about the incident when she came back to work on her next shift about one month ago. CNA #35 stated she did not report the incident because Administration already was aware of the incident and Resident #06 moved when Resident #12 approached him. Interview with Registered Nurse (RN) #600 on 12/08/25 at 4:34 P.M., revealed RN #600 heard about Resident #12 showing Resident #06 her breasts from other staff members approximately one month ago. RN #600 stated she did not report the incident because Administration was already aware. Interview with CNA #24 on 12/08/25 at 4:35 P.M., revealed CNA #24 heard about Resident #12 showing Resident #06 her breasts from other staff members approximately one month ago. CNA #24 stated she did not report the incident because Administration was already aware. CNA #24 stated staff had been trying to keep Resident #06 and Resident #12 separated. Review of the Administrator's written witness statement dated 12/09/25, revealed the Administrator spoke with Resident #06 in regard to another resident allegedly showing him her breasts. When questioned, Resident #06 stated that the incident happened a month ago. The Administrator asked if he had actually seen her breasts and Resident #06 stated no and said that he only saw her sports bra. The Administrator asked if he tried to stay away from residents and Resident #06 responded yes and he will move away from her when they are in the common area. Review of the Administrator's written witness statement dated 12/09/25, revealed the Administrator spoke with Resident #12 regarding Resident #12 allegedly exposing her breast. Resident #12 was very tearful and denied the allegation. Resident #12 stated she kept items in her bra like chapstick, so she always had her hand in there, but (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she has never exposed herself. Review of AA #55's written witness statement dated 12/09/25, revealed AA #55 was doing activities visits about one month ago. When AA #55 went into Resident #06's room, Resident #06 started to talk to AA #55 about Resident #12 flashing him. AA #55 asked him if he had seen her breasts and Resident #06 told AA #55 no. Resident #06 stated that she pulled down her jumpsuit that she had on and he saw her sports bra. Review of AA #56's written witness statement dated 12/09/25, revealed AA #56 went in Resident #06's room for activities and Resident #06 started telling her that another resident had shown him her sports bra approximately one month ago when the incident happened. Nothing was ever said to AA #56 from the resident about any other exposure of the body parts until later after he spoke with the DON. Resident #06's story started changing after that to full exposure. Interview with RN #27 on 12/10/2025 at 10:58 A.M., revealed RN #27 was not at the facility on the day of the incident, but she heard about Resident #12 showing Resident #06 her breasts in report about three to four weeks ago. RN #27 stated she did not report the incident because Administration also received report of the incident. Interview with Resident #12 on 12/10/25 at 2:21 P.M., revealed the resident denied showing Resident #06 her breasts. Resident #12 denied kissing or attempting to kiss Resident #06. Resident #12 stated that she called all the residents and staff boo because she could not remember other individual's needs due to her medical condition. Resident #12 stated she liked Resident #06 as a friend and had never made any sexual advances towards him. Interview with the Director of Nursing (DON) on 12/10/25 at 2:34 P.M., revealed the DON was not aware of Resident #12's allegedly showing Resident #06 her breasts or Resident #12 attempting to kiss Resident #06 prior to the surveyor notifying the Administrator of the alleged incident on 12/08/25. Interview with Activities Aide (AA) #56 on 12/10/25 at 2:41 P.M., revealed AA #56 went into Resident #06's room to do activities with him approximately one month ago and Resident #06 told AA #56 that Resident #12 showed Resident #06 her sports bra. AA #56 stated that she saw Resident #06 talking to the DON on that date. AA #56 reported she saw Resident #06 again after Resident #06 talked to the DON and he stated that Resident #12 showed him her breasts. AA #56 stated she told the DON when she heard that Resident #12 exposed her sports bra to Resident #06 and again when Resident #06's allegation changed to Resident #12 showing Resident #06 her breasts. AA #56 reported Resident #06 and Resident #12 were not left alone after the incident, and it was common for Resident #12 to call all the residents and staff boo. AA #56 stated that she had never seen Resident #12 expose herself but stated that Resident #12 kept items in her sports bra for storage. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with RN #27 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with RN #600 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with CNA #33 and CNA #24 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. The DON also spoke with CNA #24 who stated Resident #06 told her that Resident #12 flashed him a long time ago. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation of Resident Property policy dated 01/27/23 revealed the facility will investigate all alleged violations involving abuse. Staff should report allegations immediately to the Administrator or designee. The Administrator or their designee will notify the state agency of all alleged violations involving abuse as soon as possible but no later than 24 hours.

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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** Based on staff interview, record review, review of witness statements, review of Self-Reported Incidents (SRI), and policy review, the facility failed to thoroughly investigate an allegation of sexual abuse. This affected one (Resident #06) out of two residents reviewed for abuse. The facility census was 18.Findings include: Review of Resident #06's chart revealed Resident #49 admitted to the facility on [DATE]. Diagnosis included type two diabetes mellitus, major depressive disorder, generalized anxiety disorder, acquired absence of right leg above the knee, peripheral vascular disease, essential hypertension, dementia in other diseases classified elsewhere unspecified severity with agitation, obesity, and Duchenne or [NAME] muscular dystrophy. Review of Resident #06's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of the facility's self-reported incidents (SRIs) from 08/01/25 to 12/07/25, revealed the facility had not reported any allegations of sexual abuse or Resident #12's allegedly showing Resident #06 her breasts, Resident #12 attempting to kiss Resident #06 or Resident #12 calling Resident #06 unwanted names. Observation of Resident #06 on 12/08/25 at 2:06 P.M. revealed Resident #06 was sitting in his electric wheelchair. Resident #06 appeared clean and dressed appropriately. Interview with Resident #06 at the same time, revealed Resident #12 showed him her breasts and called him baby boo and honey. Resident #06 stated that Resident #12 tried to kiss his hand and his cheek. Resident #06 reported he was uncomfortable with Resident #12 showing him her breasts, trying to kiss him or calling him names and did not like Resident #12 making advances towards him. Resident #06 stated he told the facility staff but Resident #12 continued to make sexual advances towards him. Interview with the Administrator on 12/08/25 at 2:17 P.M., revealed the Administrator was not aware of Resident #12's allegedly showing Resident #06 her breasts or Resident #12 attempting to kiss Resident #06. The Administrator stated she was aware that Resident #12 called other residents boo. The Administrator verified there was no thorough investigation completed. Interview with Certified Nursing Assistant (CNA) #35 on 12/08/25 4:33 P.M., revealed Resident #06 told her that Resident #12 rolled up to Resident #06, lifted her shirt and said, do you like what you see. CNA #35 stated she was not present on the date of the incident but Resident #06 told her about the incident when she came back to work on her next shift about one month ago. CNA #35 stated she did not report the incident because Administration already was aware of the incident and Resident #06 moved when Resident #12 approached him. Interview with Registered Nurse (RN) #600 on 12/08/25 at 4:34 P.M., revealed RN #600 heard about Resident #12 showing Resident #06 her breasts from other staff members approximately one month ago. RN #600 stated she did not report the incident because Administration was already aware. Interview with CNA #24 on 12/08/25 at 4:35 P.M., revealed CNA #24 heard about Resident #12 showing Resident #06 her breasts from other staff members approximately one month ago. CNA #24 stated she did not report the incident because Administration was already aware. CNA #24 stated staff had been trying to keep Resident #06 and Resident #12 separated. Review of the Administrator's written witness statement dated 12/09/25, revealed the Administrator spoke with Resident #06 in regard to another resident allegedly showing him her breasts. When questioned, Resident #06 stated that the incident happened a month ago. The Administrator asked if he had seen her breasts and Resident #06 stated no and said that he only saw her sports bra. The Administrator asked if he tried to stay away from residents and Resident #06 responded yes and he will move away from her when they are in the common area. Review of the Administrator's written witness statement dated 12/09/25, revealed the Administrator spoke with Resident #12 regarding Resident #12 allegedly exposing her breast. Resident #12 was very tearful and denied the allegation. Resident #12 stated she kept items in her bra like chapstick, so she always had her hand in there, but she has never exposed herself. Review of AA #55's written witness statement dated 12/09/25, revealed AA #55 was doing activities visits about one month ago. When AA #55 went into Resident #06's room, Resident #06 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started to talk to AA #55 about Resident #12 flashing him. AA #55 asked him if he had seen her breasts and Resident #06 told AA #55 no. Resident #06 stated that she pulled down her jumpsuit that she had on and he saw her sports bra. Review of AA #56's written witness statement dated 12/09/25, revealed AA #56 went in Resident #06's room for activities and Resident #06 started telling her that another resident had shown him her sports bra approximately one month ago when the incident happened. Nothing was ever said to AA #56 from the resident about any other exposure of the body parts until later after he spoke with the DON. Resident #06's story started changing after that to full exposure. Interview with RN #27 on 12/10/2025 at 10:58 A.M., revealed RN #27 was not at the facility on the day of the incident, but she heard about Resident #12 showing Resident #06 her breasts in report about three to four weeks ago. RN #27 stated she did not report the incident because Administration also received report of the incident. Interview with Resident #12 on 12/10/25 at 2:21 P.M., revealed the resident denied showing Resident #06 her breasts. Resident #12 denied kissing or attempting to kiss Resident #06. Resident #12 stated that she called all the residents and staff boo because she could not remember other individual's needs due to her medical condition. Resident #12 stated she liked Resident #06 as a friend and had never made any sexual advances towards him. Interview with the Director of Nursing (DON) on 12/10/25 at 2:34 P.M., revealed the DON was not aware of Resident #12's allegedly showing Resident #06 her breasts or Resident #12 attempting to kiss Resident #06 prior to the surveyor notifying the Administrator of the alleged incident on 12/08/25. Interview with Activities Aide (AA) #56 on 12/10/25 at 2:41 P.M., revealed AA #56 went into Resident #06's room to do activities with him approximately one month ago and Resident #06 told AA #56 that Resident #12 showed Resident #06 her sports bra. AA #56 stated that she saw Resident #06 talking to the DON on that date. AA #56 reported she saw Resident #06 again after Resident #06 talked to the DON and he stated that Resident #12 showed him her breasts. AA #56 stated she told the DON when she heard that Resident #12 exposed her sports bra to Resident #06 and again when Resident #06's allegation changed to Resident #12 showing Resident #06 her breasts. AA #56 reported Resident #06 and Resident #12 were not left alone after the incident, and it was common for Resident #12 to call all the residents and staff boo. AA #56 stated that she had never seen Resident #12 expose herself but stated that Resident #12 kept items in her sports bra for storage. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with RN #27 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with RN #600 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. Review of the DON's written witness statement dated 12/10/25, revealed the DON spoke with CNA #33 and CNA #24 who stated that she did not personally see anything but was told in report that Resident #12 was inappropriate and they were keeping residents away from each other. The DON also spoke with CNA #24 who stated Resident #06 told her that Resident #12 flashed him a long time ago. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation of Resident Property policy dated 01/27/23 revealed the facility will investigate all alleged violations involving abuse. Staff should report allegations immediately to the Administrator or designee. The Administrator or their designee will notify the state agency of all alleged violations involving abuse as soon as possible but no later than 24 hours.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicaid & Medicare Services (CMS) timely. This affected three Residents (#03, #08, and #10) of three residents reviewed for resident assessments. The census was 18.Findings include: 1) Review of Resident #03's medical record revealed an admission date of 10/22/21. Diagnoses listed included type one diabetes mellitus, morbid obesity, and major depressive disorder. Review of MDS assessments revealed a quarterly assessment was completed 10/03/25. There was no record of the MDS assessment being transmitted to or accepted by CMS. The last quarterly MDS was completed and accepted 07/03/25. 2) Review of Resident #08's medical record revealed an admission date of 12/16/24. Diagnoses listed included type one diabetes mellitus, pseudobulbar effect, and Parkinson's disease.Review of MDS assessments revealed a quarterly assessment was completed 09/19/25. There was no record of the MDS assessment being transmitted to or accepted by CMS. The last quarterly MDS was completed and accepted 06/20/25.3) Review of Resident #10's medical record revealed an admission date of 11/09/22. Diagnoses listed included epilepsy, alcohol abuse, and Todd's paralysis.Review of MDS assessments revealed a quarterly assessment was completed 10/03/25. There was no record of the MDS assessment being transmitted to or accepted by CMS. The last quarterly MDS was completed and accepted 07/03/25.Interview with MDS Nurse #26 on 12/09/25 at 2:18 P.M. confirmed MDS assessments for Residents #03, #08 and #10 were not submitted to CMS timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365022	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Nursing and Rehabilitation	1301 North Monroe Drive Xenia, OH 45385

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure a resident's comprehensive care plan was updated. This affected one (Resident #09) of five residents reviewed for unnecessary medications. The facility census was 18.Findings include: Review of Resident #09's medical record revealed and admission date of 09/29/25. Diagnoses listed included schizophrenia, anxiety disorder, major depressive disorder, and obsessional thoughts and acts. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #09 was cognitively intact. Review of psychiatric physician note dated 11/17/25 for Resident #09 revealed a new diagnosis of schizophrenia was added. Diagnoses of major depression and anxiety were listed upon admission [DATE]. Review of Resident #09's comprehensive care plan dated 12/02/25 revealed no focus, goals, or interventions for schizophrenia, anxiety, or major depressive disorder. Interview with MDS Nurse #26 on 12/09/25 at 2:25 P.M. confirmed no focus, goals, or interventions for schizophrenia, anxiety, or major depressive disorder were listed on Resident #09's care plan. Review the facility's policy titled Care Plans, Comprehensive Person-Centered dated March 2022 revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment.