

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Xenia Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 126 Wilson 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) received 90-day and annual performance evaluations and CNAs received at least twelve hours of in-services annually. This affected three (CNA #32, CNA #36 and CNA #45) of the three CNAs reviewed for performance evaluations and annual in-services. The facility census was 34.1) Review of CNA #32's personnel file revealed CNA #32 was hired at the facility on 05/22/24. Further review of CNA #32's personnel file revealed CNA #32 did not have an annual performance evaluation from 05/22/24 to 07/30/25 and CNA #32 did not have any documented in-service education from 05/22/24 to 07/30/25. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified CNA #32 did not have an annual performance evaluation from 05/22/24 to 07/30/25 and CNA #32 did not have any documented in service education from 05/22/24 to 07/30/25. 2) Review of CNA #36's personnel file revealed CNA #36 was hired at the facility on 01/22/25. Further review of CNA #36's personnel file revealed CNA #36 did not have a 90-day performance evaluation completed from 01/22/25 to 07/30/25. Interview with Regional Support #804 on 07/31/25 at 7:33 A.M. verified CNA #36 did not have a 90-day performance evaluation completed from 01/22/25 to 07/30/25. 3) Review of CNA #45's personnel file revealed CNA #45 was hired at the facility on 09/12/23. Further review of CNA #45's personnel file revealed CNA #45 did not have any documented in service education from 09/12/24 to 07/30/25. Interview with Regional Support #804 on 07/31/25 at 7:35 A.M. verified CNA #45 did not have any documented in-service education from 09/12/24 to 07/30/25. Review of the facility's performance evaluations policy dated September 2020 revealed the job performance of each employee shall be reviewed and evaluated at least annually. A performance evaluation will also be completed on each employee at the conclusion of their 90-day probationary period. Review of the facility's undated all staff in service training revealed all staff are required to participate in regular in service education.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 365187	If continuation sheet Page 1 of 14

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food temperatures were maintained in a manner to prevent foodborne illness. This affected all 34 residents residing in the facility as the facility indicated all residents receive food from the kitchen. The facility census was 34. Observation of the facility's kitchen on 07/29/25 at 7:30 A.M. revealed [NAME] #43 was serving food from the stove and placing the made plates on the food cart that was not insulated. [NAME] #43 took the temperature of the food items on the stove and again while on the food cart. The gravy was 128.3 degrees Fahrenheit, the boiled eggs were 73.4 degrees Fahrenheit, and the scrambled eggs were 87 degrees Fahrenheit. The gravy, boiled eggs and scrambled eggs were located on the stove. The pureed scrambled eggs were 102.4 degrees Fahrenheit, the pureed oatmeal was 127.1 degrees Fahrenheit, and the pureed biscuits and gravy were 94.8 degrees Fahrenheit. The pureed scrambled eggs, the pureed oatmeal and the pureed biscuits and gravy were located on the food cart. [NAME] #43 continued to plate meals after taking the food temperatures. Interview with [NAME] #43 on 07/29/25 at 7:30 A.M. verified the gravy on the stove was 128.3 degrees Fahrenheit, the boiled eggs were 73.4 degrees Fahrenheit, and the scrambled eggs were 87 degrees Fahrenheit. [NAME] #43 also verified the pureed scrambled eggs on the food cart were 102.4 degrees Fahrenheit, the pureed oatmeal was 127.1 degrees Fahrenheit, and the pureed biscuits and gravy were 94.8 degrees Fahrenheit. [NAME] #43 stated the facility did not have a steam table to maintain the temperature of the food items.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Medical Director or his or her designee attended quarterly Quality Assessment and Assurance (QAA) committee meetings. This affected 34 out of 34 residents residing in the facility. The facility census was 34. Review of the facility's QAA meeting sign in sheets from 09/18/24 to 02/18/25 revealed the Medical Director or their designee did not attend the QAA meetings held from 09/19/24 to 02/17/25. Interview with the Administrator on 07/31/25 at 1:38 P.M. verified the Medical Director or their designee did not attend the QAA meetings held from 09/19/24 to 02/17/25.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to implement their tuberculosis control plan for tuberculosis testing of newly hired employees. This affected four (The Administrator, Licensed Practical Nurse (LPN) #30, Certified Nursing Assistant (CNA) #36 and CNA #41) out of eight newly hired employees reviewed for tuberculosis testing. This also affected 34 out of 34 residents residing in the facility. The facility census was 34. 1) Review of the Administrator's personnel file revealed the Administrator was hired at the facility on 03/06/25. Further review of the Administrator's personnel file revealed the Administrator did not have a tuberculin skin test or other test to rule out TB completed upon hire. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified the facility had no documentation that the Administrator received a TB test or interferon gamma release assay test upon hire. 2) Review of the LPN #30's personnel file revealed LPN #30 was hired at the facility on 05/08/24. Further review of LPN #30's personnel file revealed LPN #30 did not have a tuberculin skin test or other test to rule out TB completed upon hire. Interview with Regional Support #804 on 07/31/25 at 7:33 A.M. verified the facility had no documentation that LPN #30 received a TB test or interferon gamma release assay test upon hire. 3) Review of CNA #36's personnel file revealed CNA #36 was hired at the facility on 01/22/25. Further review of CNA #36's personnel file revealed CNA #36 did not have a tuberculin skin test or other test to rule out TB completed upon hire. Interview with Regional Support #804 on 07/31/25 at 7:35 A.M. verified the facility had no documentation that CNA #36 received a TB test or interferon gamma release assay test upon hire. 4) Review of CNA #41's personnel file revealed CNA #41 was hired at the facility on 02/19/25. Further review of CNA #41's personnel file revealed CNA #41 did not have a tuberculin skin test or other test to rule out TB completed upon hire. Interview with Regional Support #804 on 07/31/25 at 7:36 A.M. verified the facility had no documentation that CNA #41 received a TB test or interferon gamma release assay test upon hire. Review of the facility's employee screening for tuberculosis policy dated March 2021 revealed each newly hired employee is screened for latent tuberculosis infection and active tuberculosis infection after an employment offer has been made but prior to the employee's duty assignment. Screening includes a baseline test for latent tuberculosis infection either using a tuberculosis skin test or interferon gamma release assay, an individual assessment and a symptom evaluation. If the baseline test is negative and the individual risk assessment indicates no risk factors for acquiring TB, then no additional screening is indicated. If the baseline testing is positive, but the individual risk assessment is negative and the individual is asymptomatic, a second test with either a tuberculosis skin test or interferon gamma release assay is conducted.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident Funds Authorizations were signed and witnessed for residents that had deposited funds in resident funds accounts at the facility. This affected three (#03, #10 and #34) out of the five residents reviewed for resident funds accounts. The facility census was 34. 1) Review of the medical record for Resident #34 revealed an admission date of 10/19/19. Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, and type II diabetes mellitus (DM II). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14. Review of the facility's Resident Funds Accounts Balance Sheet dated 07/30/25 revealed Resident #34 had \$1552.74 dollars in her resident funds account. Review of Resident 34's record revealed Resident #34 did not have a Resident Funds Authorization on file at the facility. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified Resident #34 did not have a Resident Funds Authorization on file at the facility. 2) Review of Resident #03's chart revealed Resident #03 admitted to the facility on [DATE] with sepsis, type two diabetes mellitus with diabetic neuropathy, heart failure, type two diabetes mellitus with hypoglycemia without coma, sleep apnea, muscle weakness and progressive supranuclear ophthalmoplegia. Review of Resident #03's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of the facility's Resident Funds Accounts Balance Sheet dated 07/30/25 revealed Resident #03 had \$50.00 dollars in her resident funds account. Review of Resident #03's Resident Funds Authorization dated 07/16/25 revealed Resident #03 signed the Resident Funds Authorization. Further review of Resident #03's Resident Funds Authorization revealed Resident #03's Resident Funds Authorization was not witnessed. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified Resident #03's Resident Funds Authorization was not witnessed. 3) Review of the medical record for Resident #10 revealed an admission date of 08/22/22. Diagnoses included cerebral infarction, chronic obstructive pulmonary disease (COPD), and major depressive disorder. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #10 had moderate cognitive impairment as evidenced by a BIMS score of 10. Review of the facility's Resident Funds Accounts Balance Sheet dated 07/30/25 revealed Resident #10 had \$3,475.54 in her resident funds account. Review of Resident #10's Resident Funds Authorization dated 06/11/25 revealed Resident #10 signed the Resident Funds Authorization. Further review of Resident #10's Resident Funds Authorization revealed Resident #10's Resident Funds Authorization was not witnessed. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified Resident #10's Resident Funds Authorization was not witnessed.		

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure a resident on Medicaid was notified when their account reached \$200.00 dollars less than that supplemental security income (SSI) resource limit for one person and the facility failed to ensure a resident's personal funds held in a resident's funds account were conveyed within 30 days of discharge. This affected two (#31 and #48) out of the five residents reviewed for resident funds accounts. The facility census was 34. 1)Review of the medical record for Resident #31 revealed an admission date of 07/30/24. Diagnoses included cerebral infarction, hepatitis B, type II diabetes mellitus (DM II), and depression. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10. This resident was assessed to require setup with eating, dependent with toileting, bathing, dressing, and transfers. Review of Resident #31's census information dated 07/31/25 revealed Resident #31's payer source was Medicaid. Review of Resident #31's Resident Funds Statement dated 07/31/25 revealed Resident #31 had \$2,901.50 in his resident funds account. Further review of Resident #31's resident funds account revealed no documentation that Resident #31 was notified that his account reached \$200.00 dollars less than the supplemental security income (SSI) resource limit for one person. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified there was no documentation that Resident #31 was notified that his account reached \$200.00 dollars less than the SSI resource limit for one person. 2)Review of the medical record for Resident #48 revealed an admission date of 11/21/22 with a discharge date of 11/21/24. Diagnoses included cerebral infarction, hepatitis B, type II diabetes mellitus (DM II), and depression. Review of the Annual MDS assessment dated [DATE] revealed Resident #48 had intact cognition as evidenced by a BIMS score of 15. This resident was assessed to require setup with eating, toileting, bathing, dressing, and transfers. Review of the facility's check to the Attorney General's office dated 06/11/25 revealed Resident #48's account balance of \$1,218.14 was paid to the Attorney General's office on 06/11/25. Interview with the Administrator on 07/31/25 at 1:38 P.M. verified Resident #48's account balance of \$1,218.14 was not conveyed to the Attorney General's office until 06/11/25. The Administrator verified Resident #48 discharged from the facility on 11/21/24.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's code status matched in the separate paper chart and a resident's Do Not Resuscitate (DNR) order form was signed by the physician in the paper chart. This affected one (#03) of the 16 residents reviewed for code status. The facility census was 34. Review of Resident #03's chart revealed Resident #03 was admitted to the facility on [DATE] with sepsis, type two diabetes mellitus with diabetic neuropathy, heart failure, type two diabetes mellitus with hypoglycemia without coma, sleep apnea, muscle weakness and progressive supranuclear ophthalmoplegia. Review of Resident #03's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #03's paper chart revealed Resident #03 did not have a DNR order form signed by a physician in the paper chart. Review of Resident #03's Code Status Consent Form located in the paper chart dated 10/30/24 revealed Resident #03 signed a consent indicating that Resident #03 consented to a Do Not Resuscitate Comfort Care Arrest (DNRCCA) code status. The form was not signed by Resident #03's physician. Review of Resident #03's Advanced Directive Discussion Form located in the paper chart dated 02/05/24 revealed Resident #03 was a Full Code. The Advanced Directive Discussion Form was located behind Resident #03's Code Status Consent in the paper chart. There was also a paper that stated Full Code in large letters located behind the Advanced Directive Discussion Form in the paper chart. Review of Resident #03's electronic medical record (EMR) revealed a physician order dated 02/05/25 which indicated Resident #03's code status was a DNRCCA. The order was electronically signed by Physician #802 on 02/06/25. Interview with Licensed Practical Nurse (LPN) #30 on 07/28/25 at 2:09 P.M. verified Resident #03 did not have a DNR order form signed by a physician in the paper chart indicating that Resident #03's code status was changed to a DNRCCA after Resident #03 consented to changing her code status on 10/30/24. LPN #30 stated that the facility should have a DNR order form signed by the physician on file in the paper chart, but the facility could not find a DNR order form indicating Resident #03 was a DNRCCA. LPN #30 also confirmed Resident #03 had Advanced Directive Discussion Form and a sign that stated Full Code in large letters in the paper chart behind Resident #03's Code Status Consent Form. LPN #30 verified the Code Status Consent Form was not signed by the physician. Review of the facility's advanced directives policy dated September 2022 revealed the resident had the right to formulate an advanced directive.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received beneficiary notices to inform them of the right to an expedited review or about the potential non-coverage and the option to continue services with the beneficiary accepting financial liability for the services. This affected two (#46 and #47) of the three residents reviewed for beneficiary notices. The facility census was 34. 1) Review of Resident #46's chart revealed Resident #46 was admitted to the facility on [DATE] with cellulitis, other asthma, acute embolism and thrombosis of right femoral vein, rheumatoid arthritis, unspecified macular degeneration, Parkinson's disease with dyskinesia, and other intervertebral disc displacement lumbar region. Review of Resident #46's census information from 02/26/25 to 04/03/25 revealed Resident #46's payer source was Medicare Part-A from 02/26/25 to 04/03/25. Resident #46 discharged from the facility on 04/03/25. Review of Resident #46's progress notes from 02/26/25 to 04/03/25 revealed no documentation that Resident #46 received a Notice of Medicare Non Coverage (NOMNC) to inform Resident #46 of the right to an expedited review upon Resident #46's discharged from Medicare Part-A services on 04/03/25. Review of Resident #46's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified Resident #46 did not receive a NOMNC upon discharge from Medicare Part-A services on 04/03/25. 2) Review of Resident #47's chart revealed Resident #47 admitted to the facility on [DATE] with cardiac arrest, chronic obstructive pulmonary disease, maxillary fracture right side subsequent encounter for fracture with routine healing, presence of cardiac pacemaker, hypothyroidism and hyperlipidemia. Review of Resident #47's discharge MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #47's census information from 11/01/24 to 01/01/25 revealed Resident #47's payer source was Medicare Part- A from 11/01/24 to 12/17/24. Resident #47's payer source changed to private pay on 12/18/24. Resident #47's payer source remained private pay from 12/18/24 to 01/01/25. Review of Resident #47's progress notes from 11/01/24 to 01/01/25 revealed no documentation that Resident #47 received a NOMNC to inform Resident #47 of the right to an expedited review or a Skilled Nursing Facility Advanced Beneficiary Notice of Non Coverage (SNFABN) to inform Resident #47 about the potential non-coverage and the option to continue services with the beneficiary accepting financial liability for the services upon Resident #47's discharged from Medicare Part-A services on 12/17/24. Interview with Regional Support #804 on 07/31/25 at 7:31 A.M. verified Resident #47 did not receive a NOMNC or SNFABN upon discharge from Medicare Part A services on 12/17/24. This deficiency represents non-compliance investigated under Complaint Number OH001374492.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received bed hold notices for transfers to the hospital. The facility also failed to notify the Ombudsman of a resident's transfer to the hospital. This affected one (#03) of the one resident reviewed for hospitalization. The facility census was 34. Review of Resident #03's chart revealed Resident #03 was admitted to the facility on [DATE] with sepsis, type two diabetes mellitus with diabetic neuropathy, heart failure, type two diabetes mellitus with hypoglycemia without coma, sleep apnea, muscle weakness and progressive supranuclear ophthalmoplegia. Review of Resident #03's chart from 02/02/24 to 07/30/25 revealed there was no documentation that Resident #03 received a bed hold notice for her 03/25/25 and 05/17/25 discharges to the hospital. Further review of Resident #03's chart revealed no documentation that the Ombudsman was notified of Resident #03's discharge to the hospital on [DATE]. Review of Resident #03's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #03 required set up assistance with eating, oral hygiene, and personal hygiene. Resident #03 was dependent with toileting, showering, upper body dressing, lower body dressing, putting on and taking off footwear, rolling left and right, chair transfers, and tub transfers. Review of Resident #03's progress note dated 03/25/25 at 3:51 P.M. revealed Resident #03 was noted with a red rash on chest neck, and abdomen. Resident #03 was slurring her words and was confused. The Nurse Practitioner (NP) was notified, and Resident #03 was sent to the emergency room (ER) for evaluation for a possible allergic reaction. Resident #03's brother was notified. Review of Resident #03's progress note dated 03/31/25 at 11:32 P.M. revealed Resident #03 returned from the hospital. Review of Resident #03's progress note dated 05/17/25 at 5:45 P.M. revealed Resident #03 was noted with a temporal temperature of 105.0 degrees Fahrenheit and a temperature of 104.3 degrees Fahrenheit upon recheck. The nurse administered Tylenol per order and rechecked Resident #03's temperature which was 103.9 degrees Fahrenheit. The nurse contacted the on call physician regarding Resident #03's change in condition. The on call physician ordered multiple diagnostic studies, laboratory (lab) studies, and imaging. The nurse discussed the new orders with Resident #03 and Resident #03 stated she wanted to go to the hospital. The nurse contacted the on call physician to update them and the on call physician gave an order to send Resident #03 out to the ER. Resident #03 and Resident #03's family was updated. The nurse called Emergency Medical Services (EMS). Review of Resident #03's census information dated 05/23/25 revealed Resident #03 returned from the hospital on [DATE]. Interview with the Administrator on 7/31/25 at 9:14 A.M. revealed Resident #03 was not given a bed hold notice for her 03/25/25 and 05/17/25 discharges to the hospital. The Administrator also verified that the Ombudsman was not notified of Resident #03's discharge to the hospital on [DATE].		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a significant change Minimum Data Set (MDSs) assessment was completed for a resident that admitted to hospice. This affected one (#43) of 15 residents reviewed for MDS accuracy. The facility census was 34. Review of Resident #43's chart revealed Resident #43 was admitted to the facility on [DATE] with malignant neoplasm of bladder, unspecified protein calorie malnutrition, chronic obstructive pulmonary disease, anemia, atrial fibrillation, hyperlipidemia, history of falling, muscle weakness, hypokalemia, retention of urine, hydroureter and sepsis. Resident #43 was discharged from the facility on 07/05/25. Review of Resident #43's MDS assessments from 06/16/25 to 07/05/25 revealed Resident #43 did not have a significant change MDS assessment transmitted or completed upon Resident #43's admission to hospice services on 06/19/25. Review of Resident #43's quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired. Review of Resident #43's Hospice Election Form dated 06/18/25 revealed Resident #43 signed the consent to be admitted to Hospice services. Review of Resident #43's physician order dated 06/19/25 revealed Resident #43 was admitted to Hospice #800 on 06/19/25 with a diagnosis of Atherosclerosis. Interview with the Administrator on 7/30/25 at 11:54 A.M. verified Resident #43 did not have a significant change MDS assessment transmitted or completed upon Resident #43's admission to Hospice services on 06/19/25.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Xenia Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 126 Wilson 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 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 record review and staff interview, the facility failed to ensure a significant change in status Pre-admission Screening and Resident Review (PASARR) was completed for a resident with a new mental health diagnosis. This affected one (#23) of the two residents reviewed for PASARRs. The facility census was 34. Review of Resident #23's medical record revealed that he was admitted to the facility on [DATE] with diagnoses that included cerebral vascular accident, dysphagia, diabetes mellitus type 2, blindness in the right eye, congestive heart failure, bipolar disorder, anxiety, depression, malnutrition and dementia. Review of Resident #23's facility assessments from March 2025 to July 2025 revealed Resident #23 did not have a significant change PASARR completed for diagnosis of bipolar disorder. Review of Resident #23's quarterly Minimum Data Set (MDS) assessment, dated 04/30/25, revealed the resident had cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of three. Review of Resident #23's diagnosis list dated 05/07/25, revealed Resident #23 had a diagnosis of bipolar disorder, added on 12/17/23. Review of Resident #23's PASARR, dated 07/29/25, revealed that the only indication marked under serious mental illness was other psychotic disorder(s). Further review of Resident #23's medical record revealed that there was no updated PASARR completed when diagnoses for a bipolar disorder was added on 12/17/23. Interview on 07/31/25 at 11:12 A.M. with Director of Nursing (DON) revealed that the facilities process for completing PASARRs was to complete them on admission and with any significant changes. The DON stated examples for significant change would be if the resident has a hospital stay for mental health or if the resident got a new psychological diagnosis added. The DON also verified that Resident #23's PASARR dated 07/29/25 did not have mood disorder, depression or anxiety as an indication marked under serious mental illness.		

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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 review of the medical record, interviews, observations, and policy review, the facility failed to ensure residents, who were unable to carry out activities of daily living (ADLs) were provided grooming for facial hair. This affected one (#38) resident of three reviewed for ADLs. The facility census was 34. Review of the medical record for Resident #38 revealed an admission date of 01/02/25. Diagnoses included type II diabetes mellitus (DM II), altered mental status, and schizophrenia. Review of the care plan dated 01/08/25 revealed Resident #38 had an ADL self-care performance deficit related to weakness, history of being a victim of physical abuse by a family member, and trauma. Interventions included assistance with bathing/showering, setup with bed mobility, dressing, and eating, encouraged to use call light for assistance, and used walker to maximize independence with transferring. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. This resident was assessed to require setup with eating, toileting, dressing, and transfers, and substantial assistance with bathing. Observation on 07/28/25 at 3:44 P.M. revealed Resident #38 was noted to have approximately six chin hairs noted on face that were about a half an inch in length. Observation on 07/30/25 at 3:32 P.M. revealed Resident #38 was noted to have approximately six chin hairs noted on face that were about a half an inch in length. Interview on 07/30/25 at 3:35 P.M. with Resident #38 reported that her chin hairs bothered her and would like them to be groomed. Resident #38 reported no staff had offered to shave them on shower days. Interview on 07/30/25 at 3:40 P.M. with Licensed Practical Nurse (LPN) #803 verified Resident #38 had chin hairs noted. LPN #803 stated she would take care of chin hairs for Resident #38 per request. Review of the facility policy titled, Activities of Daily Living, Supporting, dated 2001 revealed residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene.		

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NAME OF PROVIDER OR SUPPLIER Xenia Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 126 Wilson Drive Xenia, OH 45385	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review, the facility failed to ensure medications were within expiration date in the medication cart. This had the potential to affect three (#02, #06, and #15) of the three residents who were administered Pro-Stat. The facility census was 34. Observation on [DATE] at 3:11 P.M. with Licensed Practical Nurse (LPN) #803, revealed the [NAME] Hall medication cart had a Pro-Stat (albuterol) inhaler opened and was expired. The manufacturer's expiration date was marked as [DATE]. Interview with LPN #803 at the same time, verified the Pro-Stat inhaler had expired and needed to be discarded. Observation on [DATE] at 3:23 P.M. with LPN #30, revealed the Emerald Hall medication cart had a Pro-Stat inhaler that was opened and expired. The manufacturer's expiration date was marked as [DATE]. Interview with LPN #30 at the same time, verified the Pro-Stat inhaler had expired and needed to be discarded. Review of the facility policy titled, Medication Storage and Labeling, dated February 2017 revealed all medications were in order and an account of all controlled medications were maintained and periodically reconciled. Medications were in accordance with currently accepted professional principles and include appropriate accessory and cautionary instructions and expiration date.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a cognitively impaired resident was explained or understood an Arbitration Agreement prior to signing the agreement. This affected one (#38) of the three residents reviewed for arbitration agreements. The facility census was 34. Review of Resident #38's chart revealed Resident #38 was admitted to the facility on [DATE] with adult physical abuse confirmed subsequent encounter, rectal prolapse, hypertension, schizophrenia, and altered mental status. Review of Resident #38's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #38 had a BIMS score of a one indicating Resident #38 was severely cognitively impaired. Review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired. Review of Resident #38's undated arbitration agreement revealed Resident #38 signed the arbitration agreement that stated she was agreeing to arbitration and waving her right to a trial by jury and the possibility of an appeal. Interview with Social Services (SS) #43 on 07/29/25 at 1:34 P.M. revealed Resident #38 signed an Arbitration Agreement on 03/28/25 with her admission packet. SS #43 stated that she explained the arbitration agreement to the resident but reported the resident was cognitively impaired. SS #43 verified Resident #38 had a BIMS of a one on 04/14/25 indicating she was severely cognitively impaired at the time the agreement was signed, and Resident #38 was not able to understand an Arbitration Agreement. SS #43 stated Resident #38 did not have a guardian or power of attorney (POA). Interview with Resident #38 on 07/30/25 at 3:35 P.M. revealed Resident #38 did not recall signing an Arbitration Agreement. Resident #38 was not aware of the meaning of an arbitration agreement. Review of the facility's Binding Arbitration Agreements policy dated November 2023 revealed the terms and conditions of binding arbitration agreements are explained to the resident or representative in a way that ensures his or her understanding of the agreement including that the resident may be giving up his or her right to have a dispute decided in a court proceeding. Interview with Resident #38 on 07/30/25 at 3:35 P.M. revealed Resident #38 did not recall signing an Arbitration Agreement. Resident #38 was not aware of the meaning of an arbitration agreement. Review of the facility's Binding Arbitration Agreements policy dated November 2023 revealed the terms and conditions of binding arbitration agreements are explained to the resident or representative in a way that ensures his or her understanding of the agreement including that the resident may be giving up his or her right to have a dispute decided in a court proceeding.		