

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, witness statements, staff and resident interviews, and policy review the facility failed to ensure respect and dignity was implemented for the residents. This affected two (#57 and #62) of two residents reviewed for dignity and respect. The census was 70.</p> <p>Findings included:</p> <p>1. Medical record review for Resident #57 revealed an admission date of 09/09/24. Medical diagnoses included cerebral vascular accident (CVA).</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was moderately cognitively impaired. His functional status was substantial/maximal assistance for eating and bed mobility, and he was dependent for toileting and for transfers. He was always incontinent for bowel and bladder.</p> <p>Review of the progress notes dated 05/02/25 for Resident #57 revealed they were silent for respect and dignity issues.</p> <p>Review of witness statement dated 05/02/25 revealed Social Service Designee (SSD) #48 interviewed Resident #57 who reported he didn't have his call light on this date and turned up his television to get someone's attention and his roommate turned on his call light and the Certified Nursing Aide (CNA) # came into the room and his depends were soaked and he couldn't remember the comment she made to him but reported she doesn't like me.</p> <p>Review of a witness statement by CNA #51 dated 05/02/25 revealed between 7:00 A.M. and 7:30 A.M. revealed CNA #51 was assisting CNA #90 with changing Resident #57 and CNA #90 got mad at the resident because she had just changed the resident and had to do it again. CNA #51 reported CNA #90 said to the resident in a rude way I just know you're going to do it again and when the resident asked her why did you say that the aide responded she couldn't explain it, she just knows.</p> <p>Review of the witness statement dated 05/02/25 by Resident #57's family revealed CNA #90 was rude to the resident this morning and the family was told after the last time the aide did this, it would not happen again and now it is happening again. The family reported if the aide didn't like her job she needed to get another one.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Disciplinary Action Form dated 05/02/25 revealed CNA #90 was educated on facility policies, job duties, and job description. This was the final major offense #16 actions detrimental to resident care due to a complaint from the family and Resident #57. The CNA was also reeducated on the attendance policy.</p> <p>Interview with the family member on 05/28/25 at 2:47 P.M. revealed the first time which he couldn't remember the date CNA #90 had to change Resident #57 and the aide told the resident you are a grown man urinating in your pants and that he acted like a little baby The family notified the previous DON and was told it wouldn't happen again. The family reported it happened again on 05/02/25 after another resident told him Resident #57 was treated badly when the CNA #90 changed the resident and belittled and scolded him for wetting his pants and this made the resident cry and wasn't himself for a couple of days after that. He reported this to the previous DON and was told the aide would not be working with the resident again. He felt like this abusive to the resident.</p> <p>Interview with Resident #57 on 05/28/25 at 4:19 P.M. revealed the CNA #90 was mean to him twice and told him he was a grown man and you shouldn't be wetting yourself and made him cry but he couldn't remember the time it made him cry. He reported the second time CNA #51 was in the room and the CNA #90 told him over and over again in a mean tone she knew she was going to have to keep changing him. The resident reported he thought it could be abuse or respect and dignity.</p> <p>Interview with Resident #57's room mate Resident #23 on 05/28/25 at 4:25 P.M. revealed CNA #90 got upset with Resident #57 because he was wetting in the bed. He reported the aide told Resident #57 you are a grown man and you shouldn't be doing that. He reported another time the CNA #90 told Resident #57 you know how hard I work and I have to come in here and clean up your bed and said don't do it again. Resident #23 reported Resident #57 cried his eyes out after this time. Resident #23 reported he told the family of the incidents, but didn't report it to the facility. He revealed he didn't know the dates of either incident. He felt like it was abusive and thought CNA #90 was way out of like the way she spoke to Resident #57.</p> <p>Interview with the Administrator on 05/29/25 at 6:55 A.M. revealed he thought the incident that happened on 05/02/25 with Resident #57 was disrespectful and the CNA #90 was unprofessional. He stated he wrote up the CNA #90 on 05/02/25 for her behavior. He didn't remember the other incident being brought to his attention and maybe the previous DON handled it.</p> <p>Interview with CNA #51 on 05/29/25 at 7:21 A.M. revealed she came into work on 05/02/25 and CNA #90 asked her to help get Resident #57 changed and out of bed. She reported CNA #90 was upset because Resident #57 was wet again and the aide kept telling the resident over and over again she knew she was going to have to change him again and again. The resident said why and the CNA said she couldn't tell him why. CNA #51 reported the resident didn't cry over this incident but was quiet for the rest of the day and didn't urinate the rest of the day. She reported she thought it was rude to the resident the way CNA #90 spoke to him and it hurt his feelings.</p> <p>2. Medical record review for Resident #62 revealed an admission date of 06/14/24. Medical diagnoses included cerebrovascular attack (CVA) and depression.</p> <p>Review of the quarterly MDS dated [DATE] revealed Resident #62 was rarely or never understood. His functional status was supervision or touching assistance for eating, dependent for toileting, bed mobility, and transfers. He was frequently incontinent for bowel and bladder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of progress notes dated 05/21/25 revealed there wasn't any notes related to this incident.</p> <p>Review of the witness statement by Resident #02 on 05/21/25 revealed during resident council meeting the night shift CNA #90 was unprofessional when speaking to Resident #02 and #62. Resident #02 asked the aide to dispose of trash that had vomit in it and when she answered the call light she told the residents what do you want, I'm busy and can't keep coming into your room. The statement further revealed the CNA #90 didn't come back and empty the trash until her shift was over which left the two residents smelling vomit all night.</p> <p>Interview with Resident #02 during resident council meeting on 05/28/25 at 11:00 A.M. reported Resident #62 wasn't able to take care of himself. He reported on 05/21/25 Resident #62 was sick and vomited in the trash can in their room and it was requested to be emptied. The CNA #90 came into the room on her cell phone the entire time of the conversation and told the two residents I don't want to come in here every half an hour to empty this bag, what do I have to do babysit you she walked out of the room and didn't come back for up to three hours to empty the trash. Resident #02 felt this was abusive and reported it to the Administrator.</p> <p>Attempted an interview with Resident #62 on 05/28/25 at 1:02 P.M. revealed he could not be understood.</p> <p>Interview with the Administrator on 05/29/25 at 6:55 A.M. revealed he thought the incident that happened on 05/21/25 with Resident #62 was disrespectful and the CNA #90 was unprofessional. He stated he had made a call to corporate to terminate the CNA #90 but had not heard back from them.</p> <p>Review of the policy entitled Resident Rights and Facility Responsibilities undated revealed the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect an promote the rights of the resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, staff interview, and medical record review, the facility failed to ensure resident rooms were maintained in a safe, comfortable, and homelike manner. This affected four (#5, #12, #41, and #47) of 70 residents residing in the facility. The facility census was 70.</p> <p>Findings include:</p> <p>1. Observation of the facility on 05/29/25 at 10:13 A.M. revealed there was exposed drywall with black spots on it in the corner of Resident #12, Resident #41, and Resident #47's room near the window. There was also a television that was on a wall mount that was removed from the wall with the screws exposed that was sitting on a night stand in Resident #12, Resident #41, and Resident #47's room.</p> <p>Interview with Maintenance Director (MD) #17 on 05/29/25 at 10:13 A.M. verified there was exposed drywall with black spots on it in the corner of Resident #12, Resident #41, and Resident #47's room near the window. MD #17 also confirmed there a television that was on a wall mount that was removed from the wall with the screws exposed that was sitting on a night stand in Resident #12, Resident #41, and Resident #47's room. MD #17 stated the windows in the resident rooms needed to be replaced due to leaks and that caused the issue with the drywall.</p> <p>2. Review of Resident #5's medical record revealed an admission date of 01/02/25 with pertinent diagnoses including unspecified fracture of the shaft of the left tibia, anemia, unspecified intellectual disabilities, epilepsy, cerebral palsy, cognitive communication deficit, and depression.</p> <p>Observation on 05/27/25 at 1:47 P.M. revealed gouges in the drywall by Resident #5's bed.</p> <p>Interview on 05/29/25 at 10:11 A.M. with MD #17 verified the gouges in the wall by Resident #5's bed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164426.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of Self-Reported Incidents (SRI), witness statement review, staff and resident interviews, and policy review, the facility failed to ensure an allegation of staff-to-resident abuse was reported to the State Survey Agency, Ohio Department of Health (ODH). This affected one (#62) of two residents reviewed for abuse. The facility census was 70.</p> <p>Findings include:</p> <p>Medical record review for Resident #62 revealed an admission date of 06/14/24. Diagnoses included cerebrovascular attack (CVA) and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was rarely or never understood and was dependent on staff for bed mobility and transfers.</p> <p>Review of a witness statement dated 05/24/25 on night shift from Resident #62 and Resident #2 revealed on 05/24/25, Resident #62 pushed his call light and 20-minutes later, Certified Nursing Assistant (CNA) #90 came to the room on her cell phone. CNA #90 stated Now what do you want? Resident #62 motioned with his hands and CNA #62 said I know you want a shower but it is going to be a couple of hours and she would be back and not to ring the call light anymore. Resident #62 put his hands as to say thank you and CNA #90 said don't you touch me I am four months pregnant this is a professional job and I am a professional at this job. CNA #90 then exited the room and came back around midnight. CNA #90 told Resident #62 she was ready to shower him, but he was going to have to help her because she wasn't going to lift him by herself. When CNA #90 picked Resident #62 up to transfer him to the chair, she flopped him down in the shower chair and then sat down in a chair in the room and there were puzzles in the chair. Resident #2 said you broke my puzzles and CNA #90 said they shouldn't be in the chair and continued to sit on them for another five minutes while talking on her phone with the speaker on while Resident #62 was sitting in the shower chair naked without any cover over him. As CNA #90 took Resident #62 down the hall, Resident #62 was trying to cover his private parts. CNA #90 brought him back wet and left him in the shower chair in the room while she was talking on the phone and telling the other person on the phone she didn't need this job. Resident #62 started drying himself and when CNA #90 was finished on the phone, she helped him dry off and then placed him back into a dirty bed. Resident #62 put his hand up to gesture thank you and CNA #90 yelled at him don't touch me I am four months pregnant and I will slap you. She left the room.</p> <p>Review of the facilities SRIs revealed this allegation of abuse involving Resident #62 and CNA #90 was not reported to ODH.</p> <p>Attempted an interview with Resident #62 on 05/28/25 at 1:02 P.M. revealed he could not be understood.</p> <p>Interview with Resident #2 on 05/28/25 at 1:15 P.M. revealed he remembered the incident he reported on 05/24/25 and provided the details he had in his witness statement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Administrator on 05/28/25 at 2:24 P.M. revealed it was reported to him CNA #90 was going to be terminated on 05/24/25 but nothing about the abuse part of the statement. He reported he didn't know anything about the allegation until 05/27/25 and verified he did not file a SRI and stated he should have reported it.</p> <p>Review of the policy titled Ohio Resident Abuse Policy dated 07/14/20 revealed all allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, witness statement review, staff and resident interviews and policy review, the facility failed to ensure an allegation of staff-to-resident abuse was investigated thoroughly. This affected one (#62) of two residents reviewed for abuse. The facility census was 70.</p> <p>Findings include:</p> <p>Medical record review for Resident #62 revealed an admission date of 06/14/24. Diagnoses included cerebrovascular attack (CVA) and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was rarely or never understood and was dependent on staff for bed mobility and transfers.</p> <p>Review of a witness statement dated 05/24/25 on night shift from Resident #62 and Resident #2 revealed on 05/24/25, Resident #62 pushed his call light and 20-minutes later, Certified Nursing Assistant (CNA) #90 came to the room on her cell phone. CNA #90 stated Now what do you want? Resident #62 motioned with his hands and CNA #62 said I know you want a shower but it is going to be a couple of hours and she would be back and not to ring the call light anymore. Resident #62 put his hands as to say thank you and CNA #90 said don't you touch me I am four months pregnant this is a professional job and I am a professional at this job. CNA #90 then exited the room and came back around midnight. CNA #90 told Resident #62 she was ready to shower him, but he was going to have to help her because she wasn't going to lift him by herself. When CNA #90 picked Resident #62 up to transfer him to the chair, she flopped him down in the shower chair and then sat down in a chair in the room and there were puzzles in the chair. Resident #2 said you broke my puzzles and CNA #90 said they shouldn't be in the chair and continued to sit on them for another five minutes while talking on her phone with the speaker on while Resident #62 was sitting in the shower chair naked without any cover over him. As CNA #90 took Resident #62 down the hall, Resident #62 was trying to cover his private parts. CNA #90 brought him back wet and left him in the shower chair in the room while she was talking on the phone and telling the other person on the phone she didn't need this job. Resident #62 started drying himself and when CNA #90 was finished on the phone, she helped him dry off and then placed him back into a dirty bed. Resident #62 put his hand up to gesture thank you and CNA #90 yelled at him don't touch me I am four months pregnant and I will slap you. She left the room.</p> <p>The facility did not have any other resident or staff interviews from night shift for 05/24/25 to review if other residents or staff witnessed the allegation of abuse.</p> <p>Attempted an interview with Resident #62 on 05/28/25 at 1:02 P.M. revealed he could not be understood.</p> <p>Interview with Resident #2 on 05/28/25 at 1:15 P.M. revealed he remembered the incident he reported on 05/24/25 and provided the details he had in his witness statement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Human Resource Director (HR) #8 on 05/28/25 at 1:41 P.M. revealed she was notified on 05/24/25 that Resident #2 had a complaint about Resident #62 and interaction with CNA #90 on 05/24/25. She stated the facility had contacted the corporate to terminate the staff member after the complaint on 05/21/25 but didn't hear back from them. She stated she called the corporate office on 05/24/25 and got the permission to terminate the aide and CNA #90 was terminated. She reported she told the Administrator they were going to terminated CNA #90 but didn't speak with him personally about it until 05/27/25.</p> <p>Interview with the Administrator on 05/28/25 at 2:24 P.M. revealed it was reported to him CNA #90 was going to be terminated on 05/24/25 but nothing about the abuse part of the statement. He reported he didn't know anything about the allegation until 05/27/25 and had barely read the statements. He verified there were no residents or staff interviewed who may had seen Resident #62 being transported down the hall naked. He confirmed he didn't conduct a thorough investigation.</p> <p>Review of the policy titled Ohio Resident Abuse Policy dated 07/14/20 revealed all allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be investigated immediately.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observation, policy review, and resident and staff interviews, the facility failed to ensure fall interventions were in place for a resident who was at a high risk for falls and had a recent fall in the facility. This affected one (Resident #40) of seven residents reviewed for falls. The facility census was 70.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #40 revealed a date of admission of 11/30/22. Diagnoses included disorder of brain, delusional disorders, cerebral infarction, tremor, muscle weakness, and paranoid schizophrenia.</p> <p>Review of the plan of care dated 08/20/24 revealed Resident #40 was at risk for falls due to cognitive impairment, muscle weakness, and unsteady gait. Interventions included educating the resident on fall prevention, performing daily checks to ensure interventions were in place, and verifying interventions during morning rounds. Specific fall interventions included a fall mat at bedside, hipsters on at all times as tolerated, bed against the wall, bilateral grab bars, non-skid strips, perimeter mattress, pressure-reducing cushion, Dycem (non-slip mat) on wheelchair, grippy socks, bed in low position with brakes on, call light within reach, and physical and occupational therapy evaluation and treatment.</p> <p>Review of the Fall Risk assessment dated [DATE] revealed Resident #40 was at high risk for falls.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had impaired cognition. Resident #40 was dependent on staff for toileting and maximum assistance from staff for bed mobility and transfers.</p> <p>Review of May 2025 physician orders for Resident #40 revealed there were orders for the fall mat, hipsters, Dycem on the wheelchair, perimeter mattress, grippy socks, bed in low position with brakes on, and other fall prevention interventions.</p> <p>Review of the nursing note dated 05/10/25 at 2:50 A.M. revealed Resident #40 was found on her knees, propped on the side of the bed, alert and oriented, and stated she could not sleep due to the roommate's snoring. No injuries were noted. The resident was assisted back to bed by staff.</p> <p>Review of the fall investigation dated 05/10/25 revealed Resident #40 was found out of bed. At the time of the fall, fall interventions, including the fall mat, hipsters, and perimeter mattress, were in place. The investigation determined the resident was noncompliant with calling for assistance, but no new interventions were added. Staff interviews indicated that ongoing monitoring and resident education were in place.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 05/27/25 at 10:26 A.M. revealed Resident #40 was sitting in her wheelchair with no Dycem in place. Activities Director #3, Certified Nursing Assistant (CNA) #75, and CNA #72 assisted Resident #40 to stand and observed there was no Dycem on the wheelchair. At 10:30 A.M., Activities Director #3, CNA #75, and CNA #72 confirmed there was no Dycem in place on Resident #40's wheelchair. Resident #40 stated she did not recall being educated on placing the Dycem on her wheelchair prior to sitting in it.</p> <p>Observation and interview on 05/28/25 at 8:39 A.M. revealed Resident #40 was eating breakfast in bed with no fall mat in place on the floor. CNA #75 confirmed the fall mat was not in place while Resident #40 was eating. Resident #40 stated the staff did not place the fall mat during the day and only placed it at night because she became confused during the night.</p> <p>Review of the facility policy titled Fall Prevention and Management Policy (revised 08/06/24) revealed residents will be assessed for fall risk(s) on admission, quarterly, and as needed. If risks are identified, preventive measures will be put in place and care planned. All falls will be reviewed and investigated. Individualized interventions will be implemented based on this assessment and care planned accordingly. The policy further defined a fall as unintentionally coming to rest on the ground, floor, or other lower level. An episode where a resident lost his/her balance and would have fallen if not for another person or if he/she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165175.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure a resident's fluid restriction was followed according to physician orders. This affected one (#29) of four residents reviewed for nutrition. The facility census was 70.</p> <p>Findings include:</p> <p>Medical record review for Resident #29 revealed an admission date of 05/06/23. Diagnoses included chronic obstructive pulmonary (COPD), vascular dementia, and congested heart failure (CHF).</p> <p>Review of the physician orders for Resident #29 dated 01/20/25 revealed a fluid restriction of 2,000 cubic centimeters (cc) for a 24-hour period. Dietary was to provide a total 1,560 cc per day, which was spread out to 600 cc at breakfast, 480 cc at lunch, and 480 cc at dinner. Nursing was to provide a total 440 cc per day, which was spread out 240 cc on first shift and 200 on second shift.</p> <p>Review of the care plan dated 03/18/25 revealed Resident #29 was at risk for nutrition/hydration related to CHF. Interventions were to monitor for signs and symptoms of dehydration and fluid overload. Encourage adequate fluid intake.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact and required setup or clean-up assistance from staff for eating,</p> <p>Observation of Resident #29's breakfast tray on 05/28/25 at 8:05 A.M. revealed she had a 480 cc container of pop on the table and she was served a 480 cc of orange juice and 480 cc of hot tea.</p> <p>Interview with the Certified Nursing Aide (CNA) #72 on 05/28/25 at 8:08 A.M. revealed Resident #29 was served 480 cc of hot tea and 480 cc of orange juice to Resident #29. CNA #72 stated she didn't know Resident #29 was on a fluid restriction.</p> <p>Review of the policy titled Intake and Output Policy dated 10/28/24 revealed: the licensed nurse will record intake and/or output for their shift as indicated on the intake and output record. At the end of the 24-hour period, the licensed nurse will total the intake and/or output on the Intake/Output Record. When intake is being recorded for fluid restrictions purposes, the licensed nurse will verify the resident has received the recommended amount and will investigate any variances. Signs and symptoms of decreased (fluid) intake and significant variances between intake and output will be communicated to the provider.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, staff interview, review of a resident census, review of drug manufacturer instructions for use, and policy review, the facility failed to ensure medications were labeled and stored in a safe and secure manner. This had the potential to affect 14 (#3, #4, #7, #18, #25, #30, #40, #42, #58, #62, #225, #226, #227, and #228) of 70 residents residing in the facility. The census was 70.</p> <p>Findings include:</p> <p>1. Observation of the 203 hall medication cart on 05/28/25 starting at 9:14 A.M. revealed there were five (5) loose pills that were a variety of shapes and colors in the medication cart with no identification to which residents the medications belonged to. Continued observation of the medication cart at 9:17 A.M. revealed there was an opened Incruse Ellipta 62.5 microgram (mcg) inhaler prescribed to Resident #7 without a date when it was opened.</p> <p>Review of a resident census dated 05/29/25 revealed five (#3, #7, #18, #30, and #58) resident's medications were stored in the 203 hall medication cart.</p> <p>Interview with Licensed Practical Nurse (LPN) #70 on 05/28/25 at 9:18 A.M. verified that the Incruse Ellipta 62.5 mcg inhaler for Resident #7 was open and undated and at 9:21 A.M. verified the 5 loose pills with no resident identification in the 203 hall medication cart.</p> <p>2. Observation of the 204 hall medication cart on 05/28/25 at 9:25 A.M. revealed there was an opened Incruse Ellipta 62.5 mg inhaler prescribed to Resident #62 without a date.</p> <p>Interview with LPN #70 on 05/28/25 at 9:25 A.M. verified that the Incruse Ellipta 62.5 mcg inhaler for Resident #62 was open and undated.</p> <p>3. Observation of the 105 hall medication cart on 05/28/25 starting at 9:32 A.M. revealed there were six (6) loose pills that were a variety of shapes and colors in the medication cart with no identification to which residents the medications belonged to. Continued observation at 9:34 A.M. revealed there was an opened Trelegy Ellipta 100 mcg inhaler prescribed to Resident #227 without a date.</p> <p>Review of a resident census dated 05/29/25 revealed eight (#4, #25, #40, #42, #225, #226, #227, and #228) resident's medications were stored in the 105 hall medication cart.</p> <p>Interview with LPN #11 on 05/28/25 at 9:39 A.M. verified there were 6 loose pills that were a variety of shapes and colors with no resident identification in the 105 hall medication cart.</p> <p>Review of the manufacturer instructions for use for Incruse Ellipta, revised December 2023, revealed the medication should be discarded after six weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used, which ever comes first.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the manufacturer instructions for use for Trelegy Ellipta, revised December 2002, revealed the medication should be discarded after six weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used, which ever comes first.</p> <p>Review of the facility's policy titled, Storage and Expiration Dating of Medications and Biologicals, with a revision date of 08/01/24, revealed the facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Further review revealed the facility should ensure the medications and biologicals for each resident are stored in the containers in which they were originally received.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of an arbitration agreement, and staff interview, the facility failed to ensure residents were explained binding arbitration agreements in a form and manner the resident can understand prior to signing them. This affected one resident (#43) of three residents reviewed for arbitration agreements. The facility census was 71.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #43 revealed the resident was admitted on [DATE] with diagnoses of unspecified dementia, hypocalcemia, encephalopathy, unspecified visual loss, atelectasis, muscle weakness, cognitive communication deficit, hallucinations, anemia, and dysphagia.</p> <p>Review of Resident #43's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) of 03.</p> <p>Review of an arbitration agreement document revealed the parties understood, acknowledged, and agreed by entering into the arbitration agreement they are voluntarily selecting arbitration as the method of resolving their disputes. By signing the arbitration agreement, they are agreeing the parties, intending to be legally bound, have been explained the agreement and each understands it as written and signs it effective as of the date above. Further review revealed Resident #43 signed the agreement on 06/24/24. The facility representative that signed the agreement was Admissions Coordinator (AC) #36 on 06/24/24.</p> <p>Interview with AC #36 on 05/28/25 at 12:06 P.M. revealed she tried to contact family and the Power of Attorney (POA) at time of Resident #43's admission; however, she was unable to get a response. AC #36 confirmed she was aware of Resident #43 being cognitively impaired and allowed Resident #43 to sign the arbitration agreement. AC#36 verified that signing the agreement was not a requirement for admissions into the facility.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, staff interview, medical record review and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure staff donned personal protective equipment (PPE) during care for a resident on Enhanced Barrier Precautions (EBP) This affected one (#18) of one resident reviewed for EBP. The facility identified 14 residents on EBP. The facility census was 70.</p> <p>Findings include:</p> <p>Review of Resident #18's medical record revealed an admission date of 01/03/25. Diagnoses included cerebrovascular disease, displaced fracture of shaft of humerus (right arm), obstructive and reflux uropathy, dysphagia, cognitive communication deficit, difficulty in walking, arteriosclerotic heart disease of native coronary artery, age related physical debility, and wedge compression fracture of first lumbar vertebrae.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/13/25, revealed Resident #18 was severely cognitively impaired and utilized a wheelchair to aid in mobility. Resident #18 had an indwelling catheter.</p> <p>Review of a physician order dated 02/12/25 revealed Resident #18 had an order for foley catheter care every shift. Further review revealed an order dated 05/15/25 for the resident to be on EBP due to foley catheter every shift.</p> <p>Observation on 05/28/25 at 11:27 A.M. of catheter care provided to Resident #18 by Certified Nursing Assistant (CNA) #72 and CNA #75 revealed a sign on the resident's door stating the resident was on EBP and to wear gloves and a gown for high contact care activities. Continued observation revealed CNA #72 and CNA #75 did not don gloves or a gown, and proceeded to provide catheter care for Resident #18.</p> <p>Interview with CNA #72 on 05/28/25 at 11:36 A.M. verified Resident #18 was on EBP and further confirmed she did not wear PPE, including gloves or a gown, while completing catheter care for the resident.</p> <p>Interview with CNA #75 on 05/28/25 at 11:37 A.M. verified Resident #18 was on EBP and further confirmed she did not wear PPE, including gloves or a gown, while completing catheter care.</p> <p>Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html</a> and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Enhanced Barrier Precautions policy, dated 05/19/25, revealed EBP were intended to prevent the transmission of multi-drug-resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk residents during high contact activities. High-risk residents included those with chronic wounds and indwelling devices (such as urinary catheters) and for all those colonized or infected with a MDRO currently targeted by the CDC. High contact care activities included activities that could result in the transfer of MDROs to the hands and clothing of healthcare personnel, even when blood and body fluid exposure was not anticipated, and included device care or use.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, hospital record review, staff interview, and review of facility policy, the facility failed to ensure appropriate antibiotics were ordered for the treatment of infections. This affected one (#23) of four residents reviewed for antibiotic stewardship. The facility census was 70.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #23 revealed an admission date of 06/22/22. Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure with hypoxia, other membranous urethral stricture, Parkinson's disease with dyskinesia, cognitive communication deficit, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, type II diabetes mellitus without complications, morbid obesity, and major depressive disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 05/16/25, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment indicated the resident was always incontinent of bowel and had an indwelling urinary catheter. The resident was (staff) dependent for toileting and personal hygiene. Further review revealed Resident #23 had a urinary tract infection (UTI) in the last 30 days.</p> <p>Review of the current plan of care revealed Resident #23 received catheter care with goals to maintain catheter patency and prevent infection. Interventions included Foley catheter changes as needed and catheter care every shift, including anchoring tubing and cleansing the catheter and perineal area with soap and water.</p> <p>Review of the current physician orders revealed Resident #23 had orders for Foley catheter care every shift and catheter changes as needed. The resident had an order initiated on 04/20/25 for Bactrim DS (sulfamethoxazole-trimethoprim) (antibiotic) 800-160 milligrams (mg) twice daily for treatment of a UTI.</p> <p>Review of the Medication Administration Record (MAR) for April 2025 confirmed Resident #23 was administered Bactrim, as ordered, for treatment of a UTI.</p> <p>Review of hospital records, dated 04/20/25, revealed Resident #23 had a urine culture with growth of greater than 100,000 colony-forming units per milliliter (CFU/mL) mixed microbes but noted suspected contamination during collection and recommended recollection and further work up. Further review revealed no sensitivity testing was performed, and no follow-up urine culture was completed to verify the appropriateness of Bactrim therapy for a UTI.</p> <p>Further review of Resident #23's medical record revealed no evidence any additional urine cultures, including sensitivity testing, were completed to determine the appropriateness of Bactrim to treat the resident's UTI.</p> <p>Interview on 05/29/25 at 11:07 A.M. with Licensed Practical Nurse (LPN) #52 verified there was no culture and sensitivity testing performed to confirm if Bactrim was an appropriate treatment for Resident #23's UTI diagnosed on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Antimicrobial Stewardship Program Policy, revised 06/26/24, revealed that the Infection Prevention and Control Committee oversees antibiotic use, emphasizing appropriate prescribing. Specifically, for UTIs, the policy mandated the use of revised McGeer's Criteria to confirm the necessity and appropriateness of antibiotic treatment, ensuring clinical and diagnostic testing aligns with infection-specific protocols to minimize unnecessary or inappropriate antibiotic use.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  London Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  218 Elm St London, OH 43140	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on interview and record review, the facility failed to ensure the COVID-19 vaccine was offered or provided to facility staff. This had the potential to affect all 70 residents residing in the facility. The facility census was 70.</p> <p>Findings include:</p> <p>Review of the staff respiratory virus information fact sheet and acknowledgement, dated 10/06/23, revealed the facility would not be administering the updated COVID-19 vaccine to team members at the facility.</p> <p>Interview with Corporate Registered Nurse (CRN) #500 on 05/29/25 at 12:51 P.M. confirmed the COVID-19 vaccination was available at the facility and further verified the facility did not offer or provide the COVID-19 vaccination to the facility staff.</p>