STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365278	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Rehabilitation and Healthcare Center	512 Crescent Drive Troy, OH 45373

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure resident rooms were clean and homelike environment. This affected two (#31 and #64) of six residents reviewed for dignity. The facility census was 133.Findings include:Review of Resident #31's medical record revealed an admission date of 12/15/25. Diagnoses included cerebral palsy and epilepsy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had severely impaired cognition and was dependent on staff for activities of daily living (ADL).Review of Resident #64 medical record revealed an admission date of 07/25/23. Diagnoses included major depressive disorder and Alzheimer's disease.Observation on 03/30/26 at 8:27 A.M. revealed an used incontinence brief on the floor between Resident #31 and Resident #64's beds. The brief was open and feces was visible. A foul odor was apparent. Resident #31 was not in the room. Resident #64 was lying in bed.Interview and observation with Certified Nurse Aide (CNA) #50 on 03/30/26 at 8:29 A.M. confirmed the incontinence brief was on the floor between Resident #31 and Resident #64's beds. CNA #505 confirmed the use incontinence briefs should not be on resident floors. CNA #505 stated nightshift had performed ADL on Resident #31.Review of the facility's policy titled Resident Right dated September 2022 revealed residents have the right of a dignified existence.This deficiency represents non-compliance investigated under Complaint Numbers 1351395 (OH00164633), 2568202, 2587182, 2662726, 2686418, 2963194, and 2971291.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, review of the facilities Self-Reported Incidents (SRIs), review of personnel files, and review of facility policy, the facility failed to report allegations of abuse and misappropriation of narcotic medications to the State Survey Agency and local law enforcement, and staff failed to timely report an allegation of misappropriation to the Administrator. This affected two (#31 and #151) of three residents reviewed for abuse and misappropriation. The facility census was 133.Findings include:1.Review of Resident #31's medical record revealed an admission date of 12/15/25. Diagnoses included cerebral palsy and epilepsy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had severely impaired cognition and was dependent on staff for activities of daily living (ADL).Review of the facilities SRIs from 03/27/26 to 03/30/26 revealed there was no SRI reported to the State Survey Agency involving Resident #31 and Certified Nurse Aide (CNA) #445.Interview with Resident #12 on 03/30/26 at 2:04 P.M. revealed he heard Resident #31 and CNA #445 in a loud verbal exchange including profanity over the past weekend. Resident #12 went out of his room to see what was going on and saw that Resident #32 was upset. Resident #12 then went to Licensed Practical Nurse (LPN) #516 and reported what he had heard. Resident #12 also reported the incident to Unit Manager #467 the same day. Resident #12 had also reported the incident to LPN #439. Resident #12 had not been interviewed by any facility management about the incident.Telephone interview on 04/01/26 at 8:55 A.M. with LPN #439 revealed Resident #12 reported concerns with CNA #445 caring for Resident #31. LPN #439 did not report the concerns to management because they had already been reported by another staff member but couldn't remember who.Telephone interview on 04/01/26 9:05 A.M with LPN #467 denied Resident #12 reported any concerns with CNA #445's care of Resident #31 to her. Interview on 04/01/26 at 9:12 A.M. with LPN #421 revealed on Monday (03/30/26), Resident #12 was venting about CNA #445's care of Resident #31. Resident #12 reported profanity was being used by CNA #445 and Resident #31. LPN #421 stated Resident #12 was truthful and protects Resident #31. LPN #421 was not interviewed by management about the incident.Telephone interview on 04/01/26 at 2:57 P.M. with LPN #516 revealed Resident #12 came to her and reported a concern with the way CNA #445 was taking care of Resident #31. Resident #12 reported Resident #31 using profanity and wasn't being taken care of properly. LPN #516 went to Resident #31's room and watched CNA #445 complete Resident #12's care and did not witness any concerns. LPN #516 did not report the incident to management because she felt it did not witness anything that would warrant any more investigation. Interview on 04/02/26 at 7:20 A.M. with the Administrator confirmed the incident Resident #12 reported to staff about CNA #445's care of Resident #31 was not investigated or reported to the State Survey Agency. Telephone interview on 04/07/26 at 9:52 A.M. revealed CNA #445 denied any abuse of Resident #31. Resident #12 had reported to the nurse that she was using profanity or something. CNA #445 did not know why Resident #12 said that. A nurse told her that she can no longer take care of Resident #31. CNA #445 was unable to name any nurses. CNA #445 was not asked by facility management about the incident until last week when someone called her.2. Review of Resident #151's closed medical record revealed an admission date of 03/04/24. Diagnoses included convulsions and osteomyelitis. Resident #151 passed away at the facility on 08/14/25. Review the physician orders revealed an order dated 08/01/25 to administer oxycodone hydrochloride (narcotic) five milligrams (mg) three times for chronic pain. An order dated 07/06/26 was for give oxycodone hydrochloride five mg one tablet as needed for chronic pain. Review of facility investigation documents revealed Licensed Practical Nurse (LPN) #565 was accused of misappropriation of Resident #151's oxycodone hydrochloride on 11/06/25. CNA #406 reported that on 08/15/25, LPN #565 told him she was going steal Resident #151 oxycodone hydrochloride. On 08/16/25 while in LPN #151's vehicle he found a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication card of Resident #151's oxycodone hydrochloride that was approximately half full in the glove compartment. CNA #406 reported being threatened by LPN #565 after he told her he found it. Review of LPN #565 personnel file revealed she was suspended on 11/06/25 and returned to work on 11/10/25. LPN #565 was then terminated on 12/17/25 when it was discovered she was not truthful during the investigation into the alleged misappropriation of Resident #151's oxycodone hydrochloride. Review of the facilities SRIs from 08/14/25 to 03/30/26 revealed there was no SRI reported to the State Survey Agency regarding the allegation of misappropriation of Resident #151's oxycodone hydrochloride. Interview on 04/02/26 at 3:20 P.M. with the Administrator confirmed the allegation of Resident #151's narcotic medications by Licensed Practical Nurse (LPN) #565 was not reported to the State Survey Agency nor to the State Board of Nursing. The Administrator stated facility corporate staff advised not to report the allegations. Follow-up interview on 04/06/26 at 8:24 A.M. with the Administrator revealed he was first made aware of the alleged misappropriation of Resident #151's oxycodone hydrochloride in November 2025. LPN #565 was suspended immediately. LPN #565 returned to work on 11/10/25 but then was terminated after she was not truthful during investigation interviews and was found to be enrolled in a drug treatment program. Investigators form the State Board of Health and State Board of Nursing had been in the facility to investigate. LPN #565 gave up her nursing license voluntarily. Interview on 04/06/26 at 9:45 A.M. with CNA #406 revealed he found a resident's narcotic medication in LPN #565's car while on lunch in August or September 2025. CNA #406 reported the Director of Nursing (DON) in November 2026. CNA #406 confirmed he should have reported sooner.Review of the facility's policy titled Abuse Investigation and Reporting dated September 2021 revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and the findings of abuse investigations will also be reported.Review of the facility's policy titled Drug Diversion Policy dated September 2024 revealed the facility will contact appropriate agencies (Board of Nursing, etc.) as appropriate.This deficiency represents non-compliance investigated under Complaint Numbers 2683813, 2697534, 2715021, 2748588, and 2963194.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, review of the facilities investigations, review of personnel files, and review of facility policy, the facility failed to thoroughly investigate allegations of abuse and misappropriation of medications. This affected two (#31 and #151) of three residents reviewed for abuse and misappropriation. The facility census was 133.Findings include:1.Review of Resident #31's medical record revealed an admission date of 12/15/25. Diagnoses included cerebral palsy and epilepsy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had severely impaired cognition and was dependent on staff for activities of daily living (ADL).The facility was unable to provide any investigation documents regarding the allegation of CNA #445 verbally abusing Resident #32.Interview with Resident #12 on 03/30/26 at 2:04 P.M. revealed he heard Resident #31 and CNA #445 in a loud verbal exchange including profanity over the past weekend. Resident #12 went out of his room to see what was going on and saw that Resident #32 was upset. Resident #12 then went to Licensed Practical Nurse (LPN) #516 and reported what he had heard. Resident #12 also reported the incident to Unit Manager #467 the same day. Resident #12 had also reported the incident to LPN #439. Resident #12 had not been interviewed by any facility management about the incident.Telephone interview on 04/01/26 at 8:55 A.M. with LPN #439 revealed Resident #12 reported concerns with CNA #445 caring for Resident #31. LPN #439 did not report the concerns to management because they had already been reported by another staff member but couldn't remember who.Interview on 04/01/26 at 9:12 A.M. with LPN #421 revealed on Monday (03/30/26), Resident #12 was venting about CNA #445's care of Resident #31. Resident #12 reported profanity was being used by CNA #445 and Resident #31. LPN #421 stated Resident #12 was truthful and protects Resident #31. LPN #421 was not interviewed by management about the incident.Telephone interview on 04/01/26 at 2:57 P.M. with LPN #516 revealed Resident #12 came to her and reported a concern with the way CNA #445 was taking care of Resident #31. Resident #12 reported Resident #31 using profanity and wasn't being taken care of properly. LPN #516 went to Resident #31's room and watched CNA #445 complete Resident #12's care and did not witness any concerns. LPN #516 did not report the incident to management because she felt it did not witness anything that would warrant any more investigation. Interview on 04/02/26 at 7:20 A.M. with the Administrator confirmed the facility did not complete an investigation into the allegation of abuse reported by Resident #12 involving CNA #445's care of Resident #31. Telephone interview on 04/07/26 at 9:52 A.M. revealed CNA #445 denied any abuse of Resident #31. Resident #12 had reported to the nurse that she was using profanity or something. CNA #445 did not know why Resident #12 said that. A nurse told her that she can no longer take care of Resident #31. CNA #445 was unable to name any nurses. CNA #445 was not asked by facility management about the incident until last week when someone called her.2. Review of Resident #151's closed medical record revealed an admission date of 03/04/24. Diagnoses included convulsions and osteomyelitis. Resident #151 passed away at the facility on 08/14/25. Review the physician orders revealed an order dated 08/01/25 to administer oxycodone hydrochloride (narcotic) five milligrams (mg) three times for chronic pain. An order dated 07/06/26 was for give oxycodone hydrochloride five mg one tablet as needed for chronic pain. Review of facility investigation documents revealed Licensed Practical Nurse (LPN) #565 was accused of misappropriation of Resident #151's oxycodone hydrochloride on 11/06/25. Certified Nursing Assistant (CNA) #406 reported that on 08/15/25, LPN #565 told him she was going steal Resident #151's oxycodone hydrochloride. On 08/16/25 while in LPN #151's vehicle, CNA #406 found a medication card of Resident #151's oxycodone hydrochloride that was approximately half full in the glove compartment. CNA #406 reported being threatened by LPN #565 after the CNA told the nurse he found it. LPN #565, LPN #438, and CNA #406 were the only staff interviewed about the allegation. No residents were documented as being interviewed. There was no (continued on next page)

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	365278	A. Building B. Wing	04/07/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of any other resident's medical record being reviewed for misappropriation until after a state health investigator and a state board of nursing investigator were at the facility on 12/04/25. Review of LPN #565 personnel file revealed she was suspended on 11/06/25 and returned to work on 11/10/25. LPN #565 was then terminated on 12/17/25 when it was discovered she was not truthful during the investigation into the alleged misappropriation of Resident #151's oxycodone hydrochloride. Interview on 04/06/26 at 8:24 A.M. with the Administrator revealed he was first made aware of the alleged misappropriation of Resident #151's oxycodone hydrochloride in November 2025. LPN #565 was suspended immediately. LPN #565 returned to work on 11/10/25 but then was terminated after she was not truthful during investigation interviews and was found to be enrolled in a drug treatment program. Investigators form the state board of health and state board of nursing had been in the facility to investigate. LPN #565 gave up her nursing license voluntarily. The Administrator confirmed the facility did not interview other residents and did not review other like residents who LPN #565 had access to their medications until after the board of health was in the facility.Review of the facility's policy titled Abuse Investigation and Reporting dated September 2021 revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be thoroughly investigated by facility management. Review of the facility's policy titled Drug Diversion Policy dated September 2024 revealed all potential drug diversions will be thoroughly investigated. This deficiency represents non-compliance investigated under Complaint Numbers 2683813, 2697534, 2715021, 2748588, and 2963194.

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	365278	A. Building B. Wing	04/07/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, policy review, and medical record review, the facility failed to ensure a resident received provide proper wound care treatment as physician ordered. This affected one (Resident #29) of seven reviewed for wound care. The facility census was 133.Findings include:Review of Resident #29's medical record revealed an admission date of 10/30/22. Diagnoses included malignant neoplasm of prostate and bone and metabolic encephalopathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively impaired.Review of the care plan dated 01/03/26 revealed Resident #29 was at risk for impaired skin integrity due to decreased mobility, incontinence, weakness, diabetes mellitus, and history of previous areas/moisture-associated skin damage (MASD). Interventions included medication(s)/treatment(s) per physician, nurse practitioner, and/or physician assistant orders.Review of the physician orders dated 03/04/26 revealed an order to apply house barrier cream, zinc, or Triad to buttock every shift. On 03/25/26, there was an additional order to cleanse left buttock with wound cleanser, pat dry, and apply Triad paste to wound bed and cover with silicone bordered gauze dressing. Change daily and as needed. Observation and interview on 03/30/26 at 2:35 P.M. of wound care performed by Licensed Practical Nurse (LPN) #495 revealed there was no dressing in place to the left buttock of Resident #29 when the area was first exposed. LPN #495 confirmed this finding upon completion of the wound care. LPN #495 confirmed there was no evidence that house barrier cream had been applied to the buttocks following incontinence care and none appeared to be present upon exposing the area.Review of the wound nurse note dated 04/01/26 revealed the wound on left buttocks was MASD and wound was improving and very minimally open. No changes to current treatment. Review of the facility policy titled Wound Care dated September 2021 revealed the purpose of the procedure is to provide guidelines for the care of wounds to promote healing. A step in the procedure included to clean wound and apply treatments as ordered by the physician.This deficiency represents non-compliance investigated under Complaint Numbers 1351395 (OH00164633), 2664481, and 2686418.

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	365278	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, observation, and facility policy review, the facility failed to ensure a resident received provide proper wound care treatment as physician ordered. This affected one (Resident #13) of seven residents reviewed for pressure ulcers. The facility census was 133. Findings include:Review of Resident #13's medical records revealed the resident was admitted on [DATE]. Diagnoses included type two diabetes mellitus, obesity, Parkinson's disease, neoplasm of behavior of bone, dementia, and peripheral vascular disease.Review of the hospital Discharge summary dated [DATE] revealed Resident #13 had a pressure injury to right buttocks measured 3.0 centimeters (cm) in length and 2.5 cm in width with 0.2 cm depth. No slough or tunneling was present.Review of the care plan dated 02/26/26 revealed Resident #13 was at risk for impaired skin integrity as evidence by an area to right sacrum and a surgical area to abdomen. Interventions included to complete treatments per physician orders and wound consult as needed.Review of Wound Nurse Practitioner #566's wound assessment dated [DATE] revealed Resident #13 was being seen for an initial consultation for wound care services. Resident #13 had a stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss.) to the right buttocks and it was present on admission. The wound measured 3.0 cm in length and 1.7 cm in width by 0.2 cm in depth. There was no tunneling and granulation tissue found. Recommendations were reduction mattress per facility protocol, reposition per facility protocol, and nutritional consultation. Review of the physician's order dated 03/25/26 to 04/01/26 revealed an order for wound care to sacrum, cleanse with wound cleanser then pat dry, apply calcium alginate to wound bed, and cover with silicone super absorbent dressing change daily or as needed. On 04/01/26, an order for the wound care to the sacrum to be changed to cleanse with wound cleanser, pat dry, apply collagen plus alginate to wound bed, and cover with silicone super absorbent dressing or a clean dry dressing change daily and as needed. Observation and interview on 04/06/26 beginning at 1:57 P.M. revealed Certified Nursing Assistant (CNA) and Unit Manager #542 were going to provide wound care to Resident #13's sacrum. There was no dressing in place to the resident's sacrum. The pressure ulcer was pink with a red center and it was open. At 2:04 P.M., Unit Manager #542 verified Resident #13 did not have a dressing on her sacrum when they began wound care. Review of the facility policy titled Wound Care dated September 2021 revealed the purpose of the procedure is to provide guidelines for the care of wounds to promote healing. A step in the procedure included to clean wound and apply treatments as ordered by the physician.This deficiency represents non-compliance investigated under Complaint Numbers 1351395 (OH00164633), 2664481, and 2686418.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of medical records, resident and staff interviews, and review of facility policy, the facility failed to ensure residents smoked only in the designated smoking areas and failed to ensure the safety of a vulnerable resident while on leave of absence (LOA). This affected four (#16, #73, #108, and #131) of twenty-eight residents reviewed for smoking and one (#50) of six residents reviewed for accidents. The census was 133.Findings include: 1. Review of Resident #50's medical record revealed an admission date of 09/26/25. Diagnoses included schizophrenia, bipolar disorder, left below the knee amputation, and peripheral vascular disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had intact cognition and a diagnosis of schizophrenia. Review of the physician orders dated 09/26/25 revealed an order that the resident may go LOA with supervision. Review of application for guardianship Statement of Expert Evaluation (SOEE) documentation dated 12/31/25 revealed Resident #50 had paranoid schizophrenia and bipolar disorder that were not stabilized or reversible. Resident #50 refuses all medications due to believing they were poison, refuses showers, keeps all her belongings by her bed in a bag, and refuses to allow medical providers to examine her. Resident #50 had impairments in thought process, affect, memory, concentration, comprehension, and judgement. A Supplement for Emergency Guardianship of Person was signed 12/31/25 but not completed. Review of the nursing note dated 12/31/25 at 5:13 P.M. revealed Resident #50 told the nurse they were leaving and didn't know if they were coming back. Resident #50 refused to sign an against medical advice (AMA) form because they wanted to come back to the facility but didn't know when they would be back. The facility's upper management was notified. Resident #50 signed the LOA book and left a contact phone number and address. Resident #50's emergency contact was updated. Nurse Practitioner (NP) #564 was notified of Resident #50 leaving LOA. The nursing note dated 01/05/26 revealed the nurse made a call to see how Resident #50 was doing on LOA. Resident #50 did not answer and a voicemail was left. Resident #50's emergency contacts were called and neither of the phone numbers listed were working. The nursing note dated 01/05/26 at 4:56 P.M. revealed Resident #50 called and stated she was stranded in Columbus, Ohio, her rights were being violated, and no one in Ohio likes her because of being an amputee. Resident #50 stated to call her if you have her best interests in mind. The unit manager was notified of the call. Review of the care plan dated 01/07/26 revealed Resident #50 had behaviors related to withdrawn, paranoia, refuses medication and orders, refuses care, refuses showers, delusions, hallucinations, non-compliant, refuses meal trays, refuses to change clothes, refuses to be weighed, hoarding, refuses wound treatments, call emergency services, call businesses and leaves obscene messages, refused to follow LOA policy, and picks at skin. Interview with the Assistant Director of Nursing (ADON) #434 on 04/01/26 at 3:33 P.M. confirmed that facility staff had not checked on Resident #50 from 12/31/25 though 01/05/26 while she was on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LOA. ADON #434 confirmed Resident #50 was paranoid and had delusions. Resident #50 had spoken in the past about attempting to go to Los Angeles, California. Interview with Registered Nurse (RN) #521 on 04/01/26 at 3:48 P.M. revealed she was the nurse on duty when Resident #50 left he facility on 12/31/25. She questioned if Resident #50 was allowed to leave the facility. Resident #50 refused to sign an AMA form because she wanted to come back. Resident #50 signed the LOA log. Resident #50 did not give a timeframe for her return to the facility. She told NP #564 that Resident #50 was wanting to leave. Interview with the Administrator on 04/02/26 at 6:54 A.M. confirmed no documentation of staff checking on Resident #50 from 12/31/25 until 01/05/26. Facility staff picked up Resident #50 from Columbus, Ohio on 01/06/26 and returned her to the facility. The Administrator confirmed Resident #50 was ordered LOA with supervision. The Administrator was unable to produce Resident #50's signature on an LOA log. Interview with NP #564 on 04/02/26 at 9:38 A.M. revealed she had completed guardianship paperwork for Resident #50. The facility's former social worker had left the paperwork in her mailbox at the facility. Resident #50 was paranoid and will not speak with NP #564 or allow to be physically assessed. Information from staff was used for the paperwork. Guardianship being established for Resident #50 was a safe decision. Review of the facility's policy titled Leave Of Absence (LOA) dated September 2022 revealed it is the policy of this facility to support a resident's right to leave the facility, including LOA, in accordance with resident rights. Residents have the right to make choices about their care and daily activities, including leaving the facility. The interdisciplinary team (IDT), in collaboration with the resident, will assess the appropriateness of a leave of absence. If the resident is not deemed Incompetent by the court, the resident retains the right to make the decision. If the resident is deemed incompetent by the court, the guardian will participate in decision-making as required by law. Overnight leaves must conform to the requirements of a resident's insurer (payer) if applicable. The resident/family need to sign resident in and out of facility on LOA form. Document a nursing progress note when resident returns and any pertinent information. This is especially important if the resident has an incident while on pass. Review of the facility's policy titled Signing Residents Out dated September 2021 revealed residents leaving should sign out. Each resident leaving the premises (excluding transfers/discharges) should sign out. A sign-out register is located at nursing station. Unless otherwise prohibited by law, medications that must be administered while the resident is out will be given to the resident/person signing the resident out. Written and/or oral instructions on when and how to administer the medication will be provided to the resident or to the person signing the resident out. Only medications that must be administered while the resident is out will be issued. Staff observing a resident leaving the premises and having doubts about the resident being properly signed out, should notify their supervisor. Restrictions noted on the resident's chart concerning who may not sign the resident out must be honored unless otherwise prohibited by facility policy or state/federal law governing such releases. Residents should sign in upon return to the facility. 2. Observation on 03/30/26 at 2:18 P.M. revealed Residents #16, #73, #108, and #131 were seated in a circle approximately eleven feet from the facility building on facility property and not in the designated smoking area. The residents were observed smoking an unidentified substance rolled in paper, which emitted a strong, pervasive odor. The item was observed being passed from one resident to another. (continued on next page)

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	365278	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Rehabilitation and Healthcare Center	512 Crescent Drive Troy, OH 45373

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/30/26 at 2:18 P.M. with Resident #131 revealed the unidentified substance rolled in paper, observed being smoke on facility grounds was marijuana. Interview 03/30/26 at 2:23 P.M. with the Administrator verified Residents #16, #73, #108, and #131 were smoking marijuana eleven feet from facility building on facility property and not in the designated smoking area. The Administrator stated education on facility smoking policy was completed on 10/07/25. Residents #73, #108, and #131 were present during education. Residents #16, #73, and #131 signed acknowledgement of the smoking policy, while Resident #108 refused to sign. Review of the facility policy titled Smoking Policy dated September 2022 revealed for those who are deemed safe to smoke independently, per smoking assessment, they may smoke at any time resident chooses in the designated smoking area. This deficiency represents non-compliance investigated under Complaint Number 2587182.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, review of Centers for Disease Control and Prevention (CDC) guidance, and facility policy review, the facility failed to ensure staff wore the appropriate proper personal protective equipment (PPE) during high contact resident care activity for a resident under enhanced barrier precautions (EBP) and staff utilized the appropriate hand hygiene during incontinence care and personal hygiene. This affected two residents (Residents #52 and #94) reviewed for infection control. The facility identified 71 residents who were under EBP. The facility census was 133. Findings include: 1. Record review for Resident #94 revealed the resident was admitted to the facility on [DATE]. Diagnoses included encephalopathy, acute respiratory failure with hypoxia, quadriplegia, anoxic brain damage, hepatitis B, hepatitis C and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 had impaired cognition and had EBP in place. Review of the current physician orders for 03/30/26 revealed Resident #94 had orders for tube feed administration through the percutaneous endoscopic gastrostomy (PEG) tube. Observation and interview on 03/30/26 at 8:30 A.M. revealed Certified Nursing Assistant (CNA) #485 provided incontinence care to Resident #94 while wearing gloves only and was not wearing a gown during the high contact resident care activity. There was a sign above Resident #94's bed for EBP stating everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and gown for the following high-contact resident care activities: dressing bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care such as central lines, urinary catheter, feeding tube, and tracheostomy. Wound care: and skin opening requiring a dressing. CNA #485 verified she did not wear a gown to provide incontinence care to Resident #94 and should have due to the resident was under EBP. Review of the care plan dated 04/04/26 revealed Resident #94 was at risk for infection due to tube feeding. Review of the facility policy titled Enhanced Barrier Precautions dated January 2024 revealed EBP refers to the use of gown and gloves during high-contact care activities for resident. The high-contact resident care activities are typical bundled care activities that are provided either during the morning and evening care and include: transferring and changing briefs. Review of the CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html 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 is 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #52's medical record revealed the resident was admitted on [DATE]. Diagnoses included type two diabetes mellitus, enterocolitis due to Clostridioides difficile (C-diff) (03/25/26). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was severely cognitively impaired. Review of the skin assessment dated [DATE] revealed Resident #52 had stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough.) on the coccyx. Resident #52 had a order for contact isolation precaution due to Resident #52 had active C. diff in stool. Resident #52 had an order for indwelling urinary catheter care every shift, and as needed. Observation and interview on 04/06/26 from 1:37 P.M. through 1:55 P.M. revealed Unit Manager (UM) #542 and Certified Nurse Aid (CNA) #482 were going to provide incontinence care and indwelling urinary catheter care for Resident #53. UM #542 verified Resident #52 had C-diff in stool. CNA #482 and UM #542 performed hand hygiene at door, placed personal protective equipment on appropriately before entering the room. CNA #482 had double gloves on both her hands. CNA #482 had her supplies on the bedside table, covered with clean linen. CNA #482 positioned Resident #52 in bed with UM #542. CNA #482 took Resident #52 dirty incontinent brief off, then cleaned Resident #52 front side with soap and water and dried at end. Resident #52's perineum area was bright red. CNA #482 then took off one pair of gloves and leaving one glove on each hand. CNA #482 did not perform hand hygiene. CNA #482 and UM #542 positioned Resident #52 to her other side to perform care on back side. CNA #482 finished washing, and drying Resident #52's backs side, and never took off her gloves, or performed hand hygiene. CNA #482 verified there was dried feces on her back side. CNA #482 continued to provide care, by placing her incontinent brief on, fixing her gown, touching her leg to roll and repositioning Resident #52, and laying her linens on top of her. CNA #482 verified she did not perform hand hygiene when providing care. CNA #482 verified she had her dirty gloves on when finishing Resident #52's care. Interview on 04/06/26 at 4:00 P.M. with Assisted Director of Nursing (ADON) #490 stated she expected staff to follow the hand hygiene policy and infection control policy when providing incontinence care, personal hygiene, and when residents were in contact precautions for C-diff. Review of the facility's undated policy titled Isolation-Initiating Transmission-Based Precaution revealed if a resident was suspected of, or identified as, or having a communicable infectious disease, the charge nurse or nursing supervisor shall notify the Infection Preventionist and the resident's attending physicians for orders. Review of the facility policy titled Hand Hygiene revealed the hand hygiene will be properly performed to assist in the prevention of spreading infections. Review of CDC guidance titled Clinical Safety: Hand Hygiene for Healthcare Workers found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html and dated 02/27/24 revealed hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of deadly germs to patients. Recommendations included on know when to wear (and change) gloves stated gloves are not a substitute for hand hygiene. If your tasks requires gloves, perform hand hygiene before donning gloves and touching the patient or the patients surroundings; always clean your hands after removing gloves. When to change gloves and clean hands included if gloves become soiled with blood or body fluids after a task, if moving from work on a soiled body site to a clean body site on the same patient or if clinical indication for hand hygiene occurs, and before exiting a patient (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. This deficiency represents non-compliance investigated under Complaint Numbers 1351395 (OH00164633) and 1351400 (OH00165900).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and resident and staff interviews, the facility failed to provide a safe and sanitary environment for residents. This affected #1, #29, and #91 and had the potential to affect the 48 residents who utilized the B-hall shower rooms. The facility census was 133.Findings include: 1. Observation on 04/06/25 at 8:21 A.M. of the B-hall shower rooms, left and right shower rooms, revealed in the right shower room, it was observed to have large brown/black spots on the floor around the toilet and into the shower area which appeared to have a wheel pattern streak on the floor. The shower stall had missing tiles near the floor and a hole approximately 12 inches by 12 inches, six inches above the floor in one of the corners of the stall. The grout on the floors and walls of the shower room had dark colored brown and black spots in some areas of the tilework. Interview on 04/06/26 at 8:22 A.M. with Unit Manager (UM) #439 verified the condition of the right shower room. UM #439 verified there was black/brown debris on the floor which appeared to be smears from a wheelchair wheels on the floor. UM #439 verified there was miscolored grout on the tiles and there was a hole in the wall and there were many missing tiles on the floor and walls. Observation and interview on 04/06/26 at 8:28 A.M. of the left shower room on B-hall revealed there was black/brown stained grout throughout the tilework and there were missing tiles on both the walls and throughout the floor. Certified Nursing Assistant (CNA) #505 verified the condition of the left shower room. CNA #505 verified the missing tiles and miscolored grout in the shower room. CNA #505 stated many residents have complained about the condition of the shower rooms during their showers. Interview on 04/06/26 at 8:32 A.M. with Resident #1 stated he does not feel comfortable while he is in either of the shower rooms on the B-hall. Resident #1 stated the shower rooms were always dirty and in disrepair. 2. Observation and interview on 03/30/26 at 11:00 A.M. revealed the wall below the air-conditioning unit mounted in the wall of Resident #29's room had crumbling plaster. The area was approximately two and a half feet wide and one foot tall. Licensed Practical Nurse #495 verified the presence of the crumbling wall in Resident #29's room. 3. Observation and interviews on 03/31/26 at 8:55 A.M. revealed the floor of Resident #91's room had large amounts of debris stuck to the floor. Resident #91 stated they rarely mop or clean his room. Observation and interview on 04/07/26 at 9:15 A.M. revealed the floor of Resident #91's had scattered black substance areas and debris. Certified Nursing Assistant (CNA) #454 verified Resident #91's floor had dark sticky substances and debris. CNA #454 stated housekeeping mops floors every other day, but stated Resident #91's floor looked bad. This deficiency represents non-compliance investigated under Complaint Numbers 1351395 (OH00164633), 2568202, 2587182, 2662726, 2686418, 2963194, and 2971291.