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	12/16/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, observations, staff interviews, and policy review, the facility failed to ensure a resident was provided privacy when toileting. This affected one (#54) out of one residents reviewed for privacy. The facility census was 131. Findings include: Review of the medical records for Resident #54 revealed an admitted [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and chronic obstructive pulmonary disease. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had range of motion impairment on one side of bilateral upper and lower extremities, required toileting hygiene, dressing, and personal hygiene, and required substantial assistance for bathing. Observation on 12/09/24 at 2:07 P.M. Resident #54 went into the shower room to use the bathroom, due to the bathroom in his room does not work. Observation of the shower room door revealed it does not shut and does not provide privacy. Interview on 12/09/24 at 2:07 P.M. with Certified Nursing Assistant (CNA) #482 confirmed Resident #54's toilet in his room is broken and has been broke for a long time and has not worked for months. Observation on 12/09/24 at 2:10 P.M. with CNA #482 confirmed Resident #54's toilet in his room is broke, by flushing the toileting which caused water to spray across the bathroom and flood onto the floor. Interview on 12/09/24 at 2:41 P.M. with Licensed Practical Nurse (LPN)/Unit Manager (UM) #426 confirmed Resident #54 does use the shower room for toileting needs due to his bathroom not working. Interview with LPN/UM #426 confirmed the shower room door is hard to close but will close when pulled forcefully. Review of the undated facility policy titled Dignity revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level satisfaction with life, and feelings of self-esteem. Residents are treated with dignity and respect.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36303 Based on observations and resident and staff interviews, the facility failed to ensure resident rooms were clean and in good repair. This affected four (#15, #36, #43, and #116) of seven resident rooms reviewed for environment. The census was 131. Findings include: 1. Observation of Resident #116's room on 12/09/24 at 11:36 A.M. revealed and adhesive fly paper strip hanging on the wall behind the head of the bed. The fly paper had dead flies and gnats on it. Interview with Resident #116 on 12/10/24 at 7:34 A.M. revealed the fly paper strip had was in the room when she moved into it. Observation revealed the fly paper strip remained on the wall. Interview with Maintenance Director (MD) #445 on 12/16/24 at 11:14 A.M. revealed a private company handles pest control for the facility. That company does not put any fly strips in resident rooms. MD #445 was unaware that a fly strip was in Resident #116's room. MD #445 confirmed fly strips should not be hung up in resident rooms and removed the fly strip. 34745 2. Observation in Resident #36's room on 12/10/24 at 8:36 A.M. revealed a pillow lying on a broken heater on the floor. The heater did not feel hot. The Activity Aide verified the pillow should not be on the heater and the vent cover looked like it was broken. Observation on 12/10/24 at 8:45 A.M. of the vent cover in Resident #36's room with MD #445 verified the vent cover for the heater was in disrepair and had not received a notification of it being broken. MD #445 revealed the heater does work along with the air conditioner and or heater which is mounted in the wall and it is unsafe. 3. Interview with Resident #15 on 12/09/24 at 11:05 A.M. revealed there was a hole under the air conditioner which allowed bugs to come into the room. Observation of the air conditioner on 12/09/24 at 11:05 A.M. revealed a large area under the air conditioner which was three fourth of the underside and there was also some insulation viewable. There was also a one and half inch gap between the air conditioner and seal which could be seen all the way outside. 4. Observation of Resident #43's room on 12/16/24 at 11:20 A.M. with MD #445 revealed a large piece of the dry wall with notes some insulation sticking out under the wall mounted air conditioner and heating unit. There was also a one and half inch gap on the left side of the unit which went all the through to the outside. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with MD #445 on 12/16/24 at 11:24 A.M. verified there was not a notification made of this issue to the unit in Resident #43's room which included missing drywall under three fourths of the unit and the gap between the window seal and unit. MD #445 also verified the facility is in the middle of updating the facility and is unsure when the second floor will be updated.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, observations, resident and staff interviews and policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded. This affected three (#67, #289 and #125) out of 26 residents reviewed during the survey. The facility census was 131. Findings include: 1. Review of the medical record for Resident #289 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. Review of the admission MDS assessment dated [DATE] revealed Resident #289 was cognitively intact. The MDS assessment coded Resident #289 does not use oxygen. Observation on 12/09/24 at 10:52 A.M. revealed Resident #289 reclining in bed with an auto-adjusting positive airway pressure (APAP) device delivering oxygen via a nose piece. Resident #289 stated the device is constantly on as he his doctors have told him he needs a lung transplant. Interview on 12/16/24 at 2:18 P.M. with Unit Manager #482 confirmed Resident #289 uses oxygen and the MDS dated [DATE] was not accurately coded. 48570 2. Review of the medical records for Resident #67 revealed an admitted [DATE] with diagnoses of acute pulmonary edema, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen. Review of the quarterly MDS assessment dated [DATE] revealed resident was cognitively intact. Resident #67 required set-up assistance with eating and oral hygiene, required supervision for with personal hygiene, required substantial assistance with bathing, bed mobility, and wheelchair mobility, and was dependent on staff assistance toileting hygiene, dressing, and transfers. Review also revealed resident did not receive oxygen therapy while a resident. Review of the Physician Order dated 08/26/24 revealed an order for oxygen at four (4) liters via nasal cannula (NC) may titrate as needed. Review of the Treatment Administration Record (TAR) for 11/2024 revealed resident received oxygen therapy at 4 liters via nasal cannula daily. Interview on 12/16/24 at 8:03 A.M. with Resident #67 revealed he wears his oxygen when he is sleeping. Interview on 12/16/24 at 8:27 A.M. with Licensed Practical Nurse (LPN)/MDS Coordinator #421 confirmed she did not mark on the quarterly MDS dated [DATE] that Resident #67 had oxygen therapy received during the look back period. Interview with LPN/MDS Coordinator #421 also confirmed Resident #67 did receive oxygen therapy daily during the look back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical records for Resident #125 revealed an admitted [DATE], a discharge date of [DATE] to the hospital, and a re-admitted [DATE], with diagnoses of post laminectomy syndrome, pressure ulcer of sacral region, stage 2, pressure ulcer of left buttock, stage 2, and pressure ulcer of right buttock, stage 2. Review if the quarterly MDS assessment dated [DATE] revealed resident was cognitively intact, required supervision with oral hygiene, required partial assistance with eating and personal hygiene, required substantial assistance with bathing and wheelchair mobility, and was dependent on staff assistance with toileting hygiene, dressing, bed mobility, and transfers. Further review revealed resident was at risk for pressure ulcers, had one unstageable pressure ulcer, had a pressure reducing device to her bed, did not have a pressure reducing device to her chair. Review of Resident #125's Encore Wound note dated 10/09/24 revealed recommendations of wheelchair pressure reduction cushion per facility protocol. Observation on 12/11/24 at 10:00 A.M. revealed a Roho style cushion in Resident #125's wheelchair. Interview on 12/11/24 at 10:34 A.M. with LPN/MDS Coordinator #421 confirmed she did not mark on the quarterly MDS assessment dated [DATE] that Resident #125 care a pressure reduction cushion in place and the MDS is coded inaccurately. Review of the MDS Completion and Submission Timeframe's policy, dated September 2021 revealed the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframe's.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on medical record review, observations, staff interviews and policy review, the facility failed to ensure the care plan was revised to accurately reflect resident care. This affected two (#16 and #125) out of 26 residents reviewed for care plans. The facility census was 131. Findings include: 1. Review of the medical records for Resident #16 revealed an admitted [DATE] with diagnoses of quadriplegia, unspecified open wound of left buttock, subsequent encounter, contracture of muscle, left hand, and contracture of muscle, right hand. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact, had impairment on bilateral upper and lower extremities. Resident #16 required set-up assistance with eating, oral hygiene, and wheelchair mobility, and required substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, bed mobility, and transfers. Review of the physician orders revealed an order for showers scheduled on Tuesday, Thursday, and Saturdays on day shift. Review of Resident #16 Care Plan with a revision date of 10/22/24 revealed resident had an Activities of Daily Living (ADL) self-care performance deficit related to requires assist with ADL's, incomplete quad, neuropathy. Resident #16 will only ambulate with therapy staff not with the nursing staff with a goal to maintain current level of function with ADL's through the review date. Resident required assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed. Resident uses motorized wheelchair for locomotion related to diagnoses of Quadriplegia, requires one (1) person assistance with toileting and transfers. Further review of the care plan revealed no documentation related to assistance needed with bathing. Observation on 12/10/24 at 8:47 A.M. Resident t#16 noted in shower room by himself. Interview with Certified Nursing Assistant (CNA) #434 confirmed Resident #16 takes three (3) hour showers every Monday, Wednesday, and Friday and that she assists him with washing his hair. Interview with CNA #434 also confirmed Resident #16 has repetitive needs, he feels he must wash his body three times, and staff washes his hair three times with each shower. Interview with CNA #434 confirmed she does not stay with him for the full shower time, she knows he is a fall risk, but this is how it has been done. Observation on 12/10/24 at 8:49 A.M. revealed CNA #434 entered shower room. Observation on 12/10/24 at 8:57 A.M. revealed CNA #434 exited shower room, reports she washed Resident #16's hair twice already. Observation on 12/10/24 at 9:07 A.M. revealed CNA #434 entered shower room. Observation on 12/10/24 at 9:08 A.M. revealed CNA #434 exited shower room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/10/24 at 9:16 A.M. revealed shower room call light flashing red. Observation on 12/10/24 at 9:19 A.M. revealed CNA #434 entered the shower room. Observation on 12/10/24 at 9:42 A.M. revealed CNA #434 exited shower room with Resident #16 in a shower chair, covered with towels and bath blanket. Interview on 12/10/24 at 9:55 A.M. with Registered Nurse (RN) #532 confirmed Resident #16 uses a slide board for transfers, can brush his teeth himself, and he uses his call light and calls for assistance when needed. Interview on 12/12/24 at 7:32 A.M. with RN/MDS Coordinator #412 and Licensed Practical Nurse (LPN)/MDS Coordinator #421 confirmed Resident #16 was not care planned for bathing and the assistance needed while bathing. 2. Review of the medical records for Resident #125 revealed an admitted [DATE], a discharge date of [DATE] to the hospital, and a re-admitted [DATE], with diagnoses of post laminectomy syndrome, pressure ulcer of sacral region, stage 2, pressure ulcer of left buttock, stage 2, and pressure ulcer of right buttock, stage 2. Review if the quarterly MDS assessment dated [DATE] revealed resident was cognitively intact, required supervision with oral hygiene, required partial assistance with eating and personal hygiene, required substantial assistance with bathing and wheelchair mobility, and was dependent on staff assistance with toileting hygiene, dressing, bed mobility, and transfers. Further review revealed resident was at risk for pressure ulcers, had one unstageable pressure ulcer, had a pressure reducing device to her bed, did not have a pressure reducing device to her chair. Review of Resident #125's Encore Wound note dated 10/09/24 revealed recommendations of wheelchair pressure reduction cushion per facility protocol. Review of the Care Plan for Resident #125 revealed no documentation related to a pressure reduction cushion. Observation on 12/11/24 at 10:00 A.M. revealed a Roho style cushion in Resident #125's wheelchair. Interview on 12/11/24 at 10:34 A.M. with LPN/MDS Coordinator #421 confirmed the intervention of pressure reducing cushion to chair that Wound Nurse Practitioner #446 ordered on 10/09/24 was not on Resident #125's care plan and should have been. Review of the Wound Care policy dated September 2021 revealed the purpose is to ensure care is provided in a way to promote healing. Review of the Care Plans, Comprehensive Person-Centered policy, dated September 2021 revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy also revealed that the care plan will include identified problems, goals and interventions to enhance the optimal functioning of the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on medical record review, observations and resident and staff interviews, the facility failed to assist residents with needed activities of daily living (ADL) care. This affected two (#16 and #31) out of six residents reviewed for ADL care. The facility census was 131. Findings include: 1. Review of the medical records for Resident #16 revealed an admitted [DATE] with diagnoses of quadriplegia, unspecified open wound of left buttock, subsequent encounter, contracture of muscle, left hand, and contracture of muscle, right hand. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact, had impairment on bilateral upper and lower extremities. Resident #16 required set-up assistance with eating, oral hygiene, and wheelchair mobility, and required substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, bed mobility, and transfers. Review of the physician orders revealed an order for showers scheduled on Tuesday, Thursday, and Saturdays on day shift. Review of Resident #16 Care Plan with a revision date of 10/22/24 revealed resident had an Activities of Daily Living (ADL) self-care performance deficit related to requires assist with ADL's, incomplete quad, neuropathy. Resident will only ambulate with therapy staff not with the nursing staff with a goal to maintain current level of function with ADL's through the review date. Resident required assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed. Resident uses motorized wheelchair for locomotion related to diagnosis Quadriplegia, requires one (1) person assistance with toileting and transfers. Further review of the care plan revealed no documentation related to assistance needed with bathing. Review of the Point of Care (POC) Response History for Scheduled Bathing on 11/30/24 at 6:59 P.M. revealed resident required physical help limited to transfer only with bathing activity, on 12/05/24 at 5:03 P.M. resident required physical help in part of bathing activity, and on 12/07/2024 at 12:31 P.M. resident required physical help in part of bathing activity. Observation on 12/10/24 at 8:47 A.M. Resident #16 noted in shower room by himself. Interview with Certified Nursing Assistant (CNA) #434 at this time confirmed Resident #16 takes three (3) hour showers every Monday, Wednesday, and Friday and that she assists him with washing his hair. Interview with CNA #434 also confirmed resident has repetitive needs, he feels he must wash his body three times, and staff washes his hair three times with each shower. Interview with CNA #434 confirmed she does not stay with him for the full shower time, she knows he is a fall risk, but this is how it has been done. Interview also confirmed resident is at risk for falls due to diagnoses, can not transfer himself, and cannot stand without assistance. Observation on 12/10/24 at 8:49 A.M. revealed CNA #434 entered shower room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/10/24 at 8:57 A.M. revealed CNA #434 exited shower room, reports she washed resident's hair twice already. Observation on 12/10/24 at 9:07 A.M. revealed CNA #434 entered shower room. Observation on 12/10/24 at 9:08 A.M. revealed CNA #434 exited shower room. Observation on 12/10/24 at 9:16 A.M. revealed shower room call light flashing red. Observation on 12/10/24 at 9:19 A.M. revealed CNA #434 entered the shower room. Observation on 12/10/24 at 9:42 A.M. revealed CNA #434 exited shower room with Resident #434 in a shower chair, covered with towels and bath blanket. Interview on 12/10/24 at 9:55 A.M. with Registered Nurse (RN) #532 confirmed Resident #16 uses a slide board for transfers, can brush his teeth himself, and he uses his call light and calls for assistance when needed. Interview on 12/12/24 at 7:32 A.M. with RN/MDS Coordinator #412 and Licensed Practical Nurse (LPN) MDS Coordinator #421 confirmed resident was not care planned for bathing and the assistance needed while bathing. Interview on 12/09/24 at 2:41 P.M. with Licensed Practical Nurse (LPN)/Unit Manager #426 confirmed Resident #16 requires assistance with all ADL;s, and the resident tends to do what he wants. Interview with LPN/Unit Manager #426 confirmed his expectations for staff is to assist Resident #16 during his shower and the resident should not be left alone in the shower room. 2. Review of the medical records for Resident #31 revealed an admitted [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and down syndrome. Review of the quarterly MDS assessment dated [DATE] revealed Resident #31 was cognitively intact, had no impairment to bilateral upper or lower extremities. Resident #31 required set-up assistance with eating, required supervision with oral hygiene, and required substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, bed mobility, transfers, ambulation and wheelchair mobility. Review of the physician orders revealed an order dated 01/15/23 to use Hoyer lift as needed, and an order dated 08/12/24 for showers on Monday and Friday on day shift. Review of the Care Plan with a revision date of 06/22/23 revealed Resident #31 required two person assistance with toileting and transfers. Review of the Quarterly Nursing Evaluation dated 11/15/24 revealed Resident #31 was at high risk for falls. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/09/24 at 2:12 P.M. revealed Resident #31 in the shower room, alone and attempting to open the door to get out of the shower room, while in her wheelchair. Another fell ow resident assisted with opening the door so Resident #31 could get out. Interview with Resident #31, revealed she was using the toilet in the shower room. Interview on 12/09/24 at 2:07 P.M. with Certified Nursing Assistant (CNA) #482 confirmed Resident #31 was in the facility shower room alone. Interview with CNA #482 also confirmed Resident #31 should not be in the shower room alone because she needs assistance with toileting and should not be going in the shower room by herself. Interview on 12/09/24 at 2:41 P.M. with Licensed Practical Nurse (LPN)/Unit Manager #426 confirmed Resident #31 should not be using the shower room for toileting due to needing assistance with toileting needs. Interview with LPN/Unit Manager #426 confirmed the shower room door is partially open, it is hard to close but will close when pulled forcefully.

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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** 48570 Based on medical record review, staff interviews, and policy review, the facility failed to ensure pressure sore treatments were complete as ordered. This affected one (#125) out of five resident reviewed for pressure ulcer care. The facility census was 131. Findings include: Review of the medical records for Resident #125 revealed an admitted [DATE], a discharge date of [DATE] to the hospital, and a re-admitted [DATE]. Diagnoses of post laminectomy syndrome, pressure ulcer of sacral region, stage 2, pressure ulcer of left buttock, stage 2, and pressure ulcer of right buttock, stage 2. Review if the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #125 was cognitively intact, required supervision with oral hygiene, required partial assistance with eating and personal hygiene, required substantial assistance with bathing and wheelchair mobility, and was dependent on staff assistance with toileting hygiene, dressing, bed mobility, and transfers. Further review revealed Resident #125 was at risk for pressure ulcers, had one unstageable pressure ulcer, had a pressure reducing device to her bed, did not have a pressure reducing device to her chair. Review of Resident #125's Treatment Administration Record (TAR) for October 2024 revealed on 10/16/24 the following treatments were not completed as ordered: Wound Care: Coccyx. Cleanse with NS and pat dry. Apply Silvadene to wound bed followed by Calcium Alginate. Cover with Composite (comfortell) dressing. Wound Care: Right Buttock. Cleanse with NS and pat dry. Apply Triad to wound bed and cover with Composite dressing (Comfortell). Wound care: right buttocks cleanse with wound cleanser, pat dry, apply triad and cover with bordered foam. Further review of the TAR revealed on 10/30/24 the follow treatments were not completed as ordered: Wound Care: Coccyx. Cleanse with 0.25% Dakins and pat dry. Apply Silvadene to wound bed and pack wound with Calcium Alginate Rope. Cover with sacral bordered foam dressing (or other foam dressing available). Wound Care: Right Buttock. Cleanse with NS and pat dry. Apply Triad to wound bed and cover with bordered foam dressing (may use sacral bordered foam if also covering sacral wound). Interview on 12/11/24 at 10:34 A.M. with Licensed Practical Nurse (LPN)/MDS Coordinator #421 confirmed Resident #125's pressure ulcer treatments were not completed as ordered on 10/16/24 and 10/30/24. 12/16/24 at 10:34 A.M. with LPN #442 confirmed Resident #125's treatments on 10/16/24 and 10/30/24 for day shift was her responsibility, and that she always signs off when she completes a treatment. Interview with LPN #442 confirmed she did not complete all treatments on 10/16/24 and 10/30/24 and that some days she just does not have time to get everything done. Review of the Wound Care policy, dated September 2021 revealed the purpose is to ensure care is provided in a way to promote healing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36303 Based on medical record review, observation, staff interviews, and review of facility policy, the facility failed to ensure interventions were in place for a resident at risk for falls. This affected one (#53) of two residents reviewed for accidents. The census was 131. Findings include: Review of Resident #53's medical record revealed an admitted [DATE]. Diagnoses included dementia with behavioral disturbance, low back pain, major depression disorder, hypertension, and Alzheimer's disease. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 was cognitively intact. Review of a care plan initiated 01/07/22 revealed Resident #53 was at risk for falls related to peripheral vascular disease, dementia with impaired cognition, and decreased mobility. Interventions listed included, keep bed in lowest position initiated on 09/14/24 and low bed initiated on 09/16/24. Review of progress notes revealed Resident #53 fell from the bed onto the floor on 09/14/24. Hospice added and intervention of fall mats to the floor of each side of Resident #53's bed. Observation of 12/11/24 at 8:50 A.M. revealed Resident #53 bed was raised and not in the lowest position. A fall mat was not on the floor to the right side of Resident #53's bed. The fall matt was folded and at the end of Resident #53's bed. Interview with Licensed Practical Nurse (LPN) #426 on 12/11/24 at 9:02 A.M. confirmed Resident #53's bed was not in the lowest position and a fall mat was not in place to the right side of the bed. LPN #426 had to move a bedside table to permit Resident #53's to be lowered to the floor and place the fall mat to the right side of the bed. Interview with the Director of Nursing (DON) on 12/11/24 at 9:16 A.M. confirmed Resident #53's bed should be in the lowest position. The DON stated the facility did not have low beds. Review of the facility's policy titled Falls dated September 2021 revealed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on medical record review, observations, staff and Nurse Practitioner (NP) #447 interviews and policy review, the facility failed to ensure indwelling catheter care was completed in accordance with the physician order and care plan. Additionally, the facility failed to ensure an adequate indication of use for an indwelling urinary catheter. This affected two (#234 and #291) out of two residents reviewed for catheter care. The facility census was 131. Findings include: 1. Review of the medical records for Resident #291 revealed an admitted [DATE] with diagnoses of encephalopathy, hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, and neuromuscular dysfunction of bladder (diagnosis added on 12/10/24). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #291 was cognitively intact, had no impairment to bilateral upper and lower extremities, required set-up assistance with eating and oral hygiene, required partial assistance with personal hygiene and bed mobility, required substantial assistance with toileting hygiene and bathing, and was dependent on staff assistance with dressing. Review of Resident #291's physician orders revealed an order on 11/13/24 for Foley Catheter record output every shift and Foley Catheter 14 French with 10 ML balloon to gravity drainage every shift for Neurogenic bladder due to retention. Review of the care plan dated 12/10/24 revealed Resident #291 has a need for indwelling catheter related to neurogenic bladder. Interview on 12/16/24 at 10:09 A.M. with Licensed Practical Nurse (LPN) #422 confirmed on admission, Resident #291 admitted with a Foley catheter, she put in the order the reason for the catheter as urinary retention with neurogenic bladder. LPN #422 further confirmed the diagnosis was not listed, and that she always puts that diagnosis in for Foley catheter orders. Interview on 12/16/24 at 10:13 A.M. with NP #447 confirmed she is unable to find information to diagnosis Resident #291 with neurogenic bladder, she felt family may have told her this was the diagnoses. NP #447 also confirmed diagnosis of neuromuscular dysfunction of bladder was added on 12/10/24, approximately one month after Resident #291 was admitted to the facility. NP #447 confirmed there was no documentation available to show Resident #291 had any urinary retention or had previous testing to confirm neuromuscular dysfunction. Interview on 12/16/24 with the Director of Nursing (DON) confirmed the facility does not have a policy on reasons to keep a Foley catheter in place. 34745 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of medical record for Resident #234 revealed admitted [DATE]. The resident was admitted with diagnoses including urinary tract infection, neuromuscular dysfunction of bladder, retention of urine. and dementia. Review of Resident #234's care plan dated 12/04/24 revealed the resident had a care plan related to an indwelling catheter which revealed individualized interventions which included document output with the catheter to be emptied every shift. Review of the physician's orders for Resident #234 was an order dated 12/04/24 for Foley catheter to record output every shift and as needed. Record review of the treatment records revealed resident Foley catheter output was not recorded on 12/06/24 for day and night shift, on 12/07/24 and 12/08/24 for night shift. Interview with the Administrator on 12/12/24 at 2:00 P.M. verified the treatment record for Resident #234 was absent for documentation of the output being documented for the dates and times of 12/06/24 for day and night shift, on 12/07/24 and 12/08/24 for night shift. Review of the facility policy titled Urinary Catheter Care dated 09/23 revealed for the section input and or output to maintain record of the residents daily output.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, observation, resident and staff interviews, and review of policy, the facility failed to ensure physician orders were in place for respiratory device and oxygen administration. This affected one (#289) out of one resident reviewed for respiratory care. The facility census was 131. Findings include: Review of the medical record for Resident #289 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. Review of the physician orders revealed no order for the use of an Automatically Adjusting Positive Airway (APAP) device. An order placed on 12/09/24 at 10:46 A.M. revealed oxygen to be administered at five liters per minute via nasal cannula. Observation on 12/09/24 at 10:52 A.M. revealed Resident #289 reclining in bed with an APAP device delivering oxygen via a nose piece. Resident #289 stated the APAP device is constantly on as he his doctors have told him he needs a lung transplant. Interview on 12/16/24 at 2:18 P.M. with Unit Manager #482 provided verification of the lack of orders for the use of an APAP device and the inaccuracy of the route of oxygen administration for Resident #289. Review of the policy titled Oxygen Administration dated 09/21, revealed the initial need is determined by documented hypoxia or a physicians order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on medical record review, observations, staff interview and policy review, the facility failed to ensure medications were administered as ordered resulting in four medication errors out of 40 opportunities or a 10 percent (%) medication error rate. This affected two (#105 and #125) out of three reviewed for medication administration. The facility census was 131. Findings include: 1. Review of the medical records for Resident #105 revealed an admitted [DATE] with diagnoses of Parkinson's disease without dyskinesia, moderate protein-calorie malnutrition and hypertensive chronic kidney disease with stage 5 chronic kidney. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #105 with severe cognitive impairment, had no impairment to bilateral upper and lower extremities. Resident #105 required partial assistance with eating and oral hygiene. Resident required substantial assistance with personal hygiene. Review of physician orders revealed an order dated 12/01/24 for Calcium 600 mg/Vitamin D 25 micrograms (mcg)-one tablet. 2. Review of the medical records for Resident #125 revealed a re-admitted [DATE] with diagnoses of post laminectomy syndrome, pressure ulcer of sacral region, stage 2, pressure ulcer of left buttock, stage 2, and pressure ulcer of right buttock, stage 2. Review of the quarterly MDS assessment dated [DATE] revealed Resident #125 was cognitively intact, had no impairment to bilateral upper and lower extremities. Resident #125 required supervision with oral hygiene and required partial assistance with eating and personal hygiene. Review of the physician orders for Resident #125 revealed an order dated 09/19/24 for Ferrous Gluconate 324 milligrams (mg) (38 Fe) mg-one tablet, for Magnesium Glycinate 100 mg-one tablet and for Calcium 1000 + D Oral Tablet 1000-20 MG-MCG (Calcium Carbonate-Cholecalciferol) give 1 tablet daily. Observation on 12/11/24 8:53 A.M. of medication administration to Resident #125 with Licensed Practical Nurse (LPN) #442 revealed Iron 27 (Fe) mg Ferrous Gluconate one tablet was administered, but the physician order was for Ferrous Gluconate 324 mg (38 Fe) mg-one tablet. Magnesium Glycinate 400 mg-one tablet was administered, but the physician order was for Magnesium Glycinate 100 mg- one tablet. The observations revealed Calcium 1000/20 mg +D was not available to administer to Resident #123 due to facility was out of this medication. Observation on 12/11/24 9:25 A.M. of medication administration revealed #442 administered Calcium 600 + D 10 mcg-one tablet to Resident #105, but the physician order was for Calcium 600 mg/Vitamin D 25 mcg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/11/24 12:21 P.M. with LPN #442 confirmed Resident #125 was administered Iron 27 (Fe) mg Ferrous Gluconate one tablet and the physician order was for Ferrous Gluconate 324 mg (38 Fe) mg one tablet. Magnesium Glycinate 400 mg one tablet was administered, the physician order was for Magnesium Glycinate 100 mg-one tablet. Calcium 1000/20 mg +D was not available to administer to Resident #105 due to facility was out of this medication, and she signed the Medication Administration Record as awaiting on provider, so provider can order something else. LPN #442 confirmed she administered Calcium 600 + D 10 mcg-one tablet to Resident #105 and the physician order was for Calcium 600 mg/Vitamin D 25 mcg-one tablet. Review of an undated facility policy titled Administering Medications revealed medications shall be administered in a safe and timely manner.

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, staff, Nurse Practitioner (NP) #447, Physician #448 and Neurologist #449 interviews, review of medication information from Medscape, and policy review, the facility failed to appropriately reconcile medications following a hospital re-admission resulting in a significant medication error. This resulted in Actual Harm when Resident #96 was readmitted from the hospital on 10/03/24 and the facility failed to appropriately reconcile the resident's transfer orders resulting in the resident's anticonvulsant medication being abruptly stopped on 11/06/24 and Resident #96 subsequently began having seizure activity on 11/11/24 which resulted in re-hospitalization . This affected one (#96) of one resident reviewed for hospitalization . The facility census was 131. Findings include: Review of the medical record of Resident #96 revealed an original admitted [DATE]. Diagnoses include metabolic encephalopathy, epilepsy without status epilepticus, transient ischemic attack and cerebral infarction. Review of the hospital admission orders dated 10/03/24 revealed an order for Keppra (anticonvulsant) 750 milligrams (mg) to be administered twice daily for 30 days. A follow-up appointment was scheduled for 11/19/24 with a neurologist Advanced Practice Registered Nurse. Review of the Resident #96's Assessment and Plan, documented by a Hospitalist, dated 10/03/24, revealed a routine electroencephalogram (EEG), completed on 08/30/24, revealed consistent with epileptogenic right hemisphere structural lesion which is prone to focal seizures. Intravenous Keppra load with Keppra was ordered. The plan included to continue Keppra. This form was not printed at the facility at the time of re-admission on 10/03/24. The form was printed by the facility upon the surveyor's request on 12/11/24. Review of Resident #96's progress notes revealed no indication the physician was called to clarify the Keppra stop date. Review of the physician note dated 10/07/24, documented by Physician #448, revealed Resident #96 was seen for readmission from hospital with urinary tract infection, and sepsis with metabolic encephalopathy. Review of the Medication Administration Record for the month of 11/24 revealed Resident #96's Keppra was last given on 11/06/24 at 7:00 A.M. Review of a progress note, documented by NP #563, dated 11/11/24 revealed Resident #96's wife was stating his eyes were doing something weird. The nurse had explained the wife reported eyes were twitching or jerking, but this was not witnessed by the nurse. NP #563 agreed to send him to the emergency room (ER). Review of Resident #96's progress note dated 11/11/24 at 10:17 P.M. revealed the resident was sent to the ER at 9:45 P.M. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #96's hospital Discharge Summary, documented by a hospital physician, dated 11/14/24 revealed reason for admission on 11/11/24 principal diagnosis seizure in the setting of missed doses of Keppra. The Hospital Course and Treatment revealed Resident #96 had missed his Keppra dosing as there was some miscommunication in the nursing home regarding the continuation of Keppra dosing and was admitted with seizure activity. Review of the hospital Neurology consult note, dated 11/12/24, revealed an assessment of provoked seizure in setting of noncompliance with Keppra (not continued at extended care facility) for unknown reasons. Interview on 12/11/24 at 8:46 A.M. with NP #447 and the Director of Nursing (DON) revealed they were unaware of the diagnosis of epilepsy and the 30-day order of Keppra for Resident #96. The DON confirmed Resident #96's Keppra was abruptly stopped without consulting neurology. The DON and NP #447 both stated they were not able to view the Hospitalist Progress Note dated 10/03/24 by a hospital physician as they did not have access to the hospital records but were able to print them upon the surveyor's request. The DON stated it would be her expectation for nurses to question any order they see fit and notify the provider of the questions for clarification. NP #447 stated she thought the half-life of Keppra was eight to 12 hours. The DON stated, We just follow the orders. Interview on 12/11/24 at 10:55 A.M. with Licensed Practical Nurse (LPN) #454 revealed she did not notice the stop date for the Keppra but would have questioned it. Interview on 12/11/24 at 1:24 P.M. with Physician #448, NP #447, and the DON revealed Physician #448 stated the Keppra regimen depends on the patient. When a resident experiences a cardiovascular accident and then has seizures, the Keppra can be stopped abruptly. Physician #448 stated Resident #96 was experiencing acute post stroke seizure, and these are treated differently. Most neurologists treat seizures differently. Physician #448 stated during treatment it would be normal to check a patient to see if they are still having seizures. Physician #448 stated Keppra can be continued for up to two months but would depend on whether or not any seizures occurred during that time. If no seizure activity is experienced the medication may be stopped abruptly. Physician #448 stated he had not been aware of the 30-day stop order but it would not have made a difference in his treatment. If any seizure activity had been reported during treatment, he would have continued the Keppra. Physician #448 confirmed he had received no notifications of any seizure activity, shaking, eye twitching, mouth flopping, incontinence, or tongue biting. Physician #448 stated a diagnosis of epilepsy would indicate to continue Keppra for the rest of your life. A telephone interview on 12/12/24 at 11:17 A.M. with Neurologist #449 revealed seizures following a stroke are rare. Neurologist #449 stated he would have expected Resident #96's Keppra to be continued until the resident followed up with neurology, when an electroencephalogram would have been completed to determine the need or not of medication continuation. Neurologist #449 stated Keppra has very little side effects and is very safe to take. Review of medication information from Medscape at https://reference.medscape.com/drug/keppra-spritam-levetiracetam-343013#0 revealed Keppra is used to treat seizure disorder. Do not stop taking this medication without consulting your doctor. Your seizures may become worse when the drug is suddenly stopped. You should avoid abrupt withdrawal of Keppra to reduce the risk of increased seizure frequency and status epilepticus. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of an undated facility policy titled Administering Medications revealed medications shall be administered in a safe and timely manner.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, review of arbitration agreements and staff and resident interviews, the facility failed to ensure facility staff knew a residents' cognitive status and ability to understand before having the resident sign an arbitration agreement. This affected one (#283) of four residents reviewed for arbitration agreements. The census was 131. Findings include: Review of Resident #283's medical record revealed an admitted [DATE]. Diagnose listed included type two diabetes mellitus, hypertensive heart disease, muscle weakness, prostate cancer, and vascular dementia. Review of a quarterly Minimum data Set (MDS) assessment dated [DATE] revealed Resident #283 had severe cognitive impairment. Resident #283's brief interview for mental status (BIMS) score was four out of a possible 15. Review of social service assessment notes dated 11/21/24 at 9:10 A.M. revealed Resident #283 was alert and oriented times one (new his name). Resident #283 had a history of dementia. Review of general progress notes dated 11/21/24 at 9:10 A.M. revealed Resident #283's family expressed concerns with wandering. A new elopement assessment was completed and a wanderguard (elopement alarm device) was placed on Resident #283's left lower leg. Review of general progress notes dated 11/21/24 at 3:56 P.M. revealed per a care plan from earlier this year when Resident #283 was at the facility he had a history of refusing care at times, wandering in and out of other resident rooms, and increased anxiety with increased confusion. Review of Resident #283's Alternative Dispute Resolution Agreement revealed is was signed on 11/27/24. A written X was in area were Resident #283 signed. Resident #283's signature was illegible and written through the X. A box was marked to accept the alternate dispute resolution. There was a section on the signature page where a guardian of the person, guardian of the estate, power of attorney (healthcare or financial), or responsible parties could sign. There was not a signature is this area. Within the alternate dispute resolution agreement was the statement, The parties understand, acknowledge, and agree that they are selecting a method of resolving disputes without filing lawsuits or involving the courts, and that by entering into this agreement they are giving up their constitutional right to have their disputes decided in a court of law by a judge or jury, the opportunity to present their claims as a class action and/or to appeal any decision or award of damages resulting from the ADR (alternate dispute resolution) process except as provided herein. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Business Development (DOBD) #511 and Coordinator of Admissions (COA) #414 on 12/12/24 at 9:52 A.M. revealed arbitration agreements are signed during the admission process. Residents sign in one area on a iPad (handheld computer tablet) and that signature will populate to all areas of the resident agreement including the arbitration agreement. A box is marked to accept or decline the agreement. COA #414 and DOBD #511 explain to residents that if they accept the arbitration agreement they will not have to hire a lawyer. COA #414 stated she will never get a signature without knowing if a resident understands. Sometimes there is a need to call family. COA #414 and DOBD #511 do not check BIMS scores before having residents sign arbitration agreements. Interview with the Administrator, DOBD #511, and COA #414 on 12/12/24 at 3:50 P.M. revealed Resident #283 had a BIMS score of four and currently resided in the memory care unit. Resident #283 did sign the resident agreement including the arbitration agreement with DOBD #511. COA #414 and #511 do not check Resident #283's BIMS score before having residents sign arbitration agreements. They asked Resident #282 if the he understood the agreement. DOBD #511 went over the admission agree including the arbitration agree with Resident #283. Resident #283's family was not present. The Administrator stated that if residents are legally deemed incompetent she would be violating their rights by having family/representative sign in their place. Interview with Resident #283 on 12/16/24 at 10:07 A.M. revealed he was alert and oriented times one. Resident #283 was not able to state where he was, what year or month it was, and stated he had been in the facility about a year.

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	12/16/2024

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 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** 34745 Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to maintain infection control protocols for an indwelling urinary catheter bag and tubing. This affected one (#234) out of two residents reviewed for urinary catheter care. The census was 131. Findings included: Review of medical record for Resident #234 revealed admitted [DATE]. The resident was admitted with diagnoses including urinary tract infection, neuromuscular dysfunction of bladder, retention of urine. and dementia. Review of the physician's orders for Resident #234 dated 12/04/24 for Foley catheter care every shift. A care plan for Resident #234 dated 12/04/24 related to indwelling catheter revealed individualized interventions which included maintaining drainage bag below the bladder level. Observation on 12/12/24 at 8:30 A.M. of Resident #234 was in bed with eyes closed and his indwelling urinary catheter bag and tubing was lying on the floor under the bed rail. Interview with Licensed Practical Nurse #439 on 12/12/24 at 8:32 A.M. verified Resident #234's indwelling urinary catheter bag and tubing should not be on the floor due to infection control. Review of the facility policy titled Urinary Catheter Care dated 09/23 revealed for the section infection control to be sure the catheter tubing and drainage bag are kept off the floor.