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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365364 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/30/2026 |
| NAME OF PROVIDER OR SUPPLIER Trotwood Health & Rehab LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4911 Covenant House Drive Dayton, OH 45426 | |

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) |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility self-reported incident (SRI), review of a police report, staff interview and policy review, the facility failed to ensure residents were from staff to resident physical abuse with serious injury. This resulted in Immediate Jeopardy and Actual Harm on 04/18/26 at approximately 10:40 A.M. when Dietary Aide (DA) #51 punched Resident #4 in the face. Resident #4 was admitted to the hospital with a broken jaw. This affected one (Resident #4) of three residents reviewed for abuse. The facility census was 29 residents.</p> <p>On 04/23/26 at 10:32 A.M., the Administrator was notified Immediate Jeopardy began on 04/18/26 at approximately 10:40 A.M. when DA #51 punched Resident #4.</p> <p>The Immediate Jeopardy was removed on 04/24/26 when the facility implemented the following corrective actions:</p> <p>On 04/18/26 at 10:40 A.M., Certified Nurse Aide (CNA) #86 separated DA #51 and Resident #4 to provide for resident safety and obtained assistance from Registered Nurse (RN) #71.</p> <p>On 04/18/26 at 10:42 A.M., Dietary Manager (DM) #50 escorted DA #51 off the unit. The Administrator suspended DA #51 pending investigation.</p> <p>On 04/18/26 at 10:43 A.M., RN #71 assessed Resident #4 for injury and administered first aid to the resident who had some bleeding from his nose and mouth.</p> <p>On 04/18/26 at 10:44 A.M., RN #71 notified the Director of Nursing (DON) of the incident.</p> <p>On 04/18/26 at 10:47 A.M. DM #50 phoned the DON to confirm DA #51 was awaiting law enforcement under the DM's supervision.</p> <p>On 04/18/26 at 10:47 A.M., the DON notified the Administrator. (continued on next page)</p> |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 04/18/26 at 10:57 A.M., RN #71 called emergency services (EMS) and local law enforcement via 911. Resident #4 initially refused transport to the hospital, and EMS left.</p> <p>On 04/18/26 at 11:01 A.M., RN #71 contacted Resident #4's sister with notification of the incident and the resident's refusal of transfer to the hospital. Resident #4's sister was able to persuade the resident to go the hospital. RN #71 contacted EMS again, and they transported the resident to the hospital.</p> <p>On 04/18/26 at 10:58 A.M. the DON notified the Chief Nursing Officer (CNO) of the incident.</p> <p>On 04/18/26 at 11:15 A.M., DM #50 obtained a statement from DA # 51 regarding the incident.</p> <p>On 04/18/26 at 11:40 A.M., the Administrator initiated an SRI with the Ohio Department of Health (ODH) documenting there had been an altercation between DA #51 and Resident #4. The SRI documented the incident had no ill effects on Resident 4, and the resident remained at baseline.</p> <p>On 04/18/26 at 11:57 A.M., DA #51 met with law enforcement outside of the building in the facility parking lot.</p> <p>On 04/18/26 at 12:13 P.M., the Administrator and the DON advised DA #51 to leave the facility property and not to return but to be available by telephone to speak with the Administrator and DON to complete an investigation interview.</p> <p>On 04/18/26 the Administrator, the DON, the CNO, and the Chief Operating Officer (COO) completed a root cause analysis of the incident and determined the following root causes: unknown male on the unit, medication changes, decline in cognition.</p> <p>On 04/18/26, the DON/Designee began all staff education on abuse prevention initiated which included a follow-up post-test. Any employee not receiving all education by this date will receive prior to next scheduled shift.</p> <p>On 04/20/26, the DON/Designee began all staff education that employees should not enter the secured unit unless they have assigned duties in that area. All education was concluded on 04/21/26. Any employee not receiving all education by this date will receive prior to next scheduled shift.</p> <p>On 04/18/26, the following staff completed written witness statements regarding the incident: CNA #86, CNA #11, RN #71, DA #51. (continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 04/18/26, the nurse on duty conducted body audit on residents with a Brief Interview of Mental Status (BIMS) score below 12 (moderate cognitive impairment) with no evidence of abuse identified.</p> <p>On 04/20/26, the Social Service Director (SSD) conducted interviews with residents with a BIMS score of 12 (cognitively intact) and above with no concerns of abuse identified.</p> <p>On 04/20/26, the Clinical Consultant (CC) reviewed the facility grievance logs for the duration of DA #51's tenure with the facility and identified no concerns.</p> <p>On 04/20/26, the CC reviewed the facility incident logs for the duration of DA #51's tenure and identified no concerns.</p> <p>On 04/20/26, the CC reviewed DA #51's criminal background check and identified the aide had no criminal acts involving physical assault or altercations recorded.</p> <p>On 04/20/26 at 10:15 A.M., the facility implemented monitoring to confirm the only employees to enter the secured unit were those who were assigned to perform specific duties on the unit, and to ensure no other staff members entered the unit. Monitoring will continue two times per day for four weeks and then three times per week for two months. All concerns will be addressed at time of discovery.</p> <p>On 04/18/26 an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held which included the Administrator, the DON, the Chief Operating Officer (COO), the CNO, and DM #50.</p> <p>On 04/20/26, the Resident Assessment Coordinator (RAC) and the Medical Director (MD) were included in the ad hoc QAPI actions.</p> <p>On 04/21/26 at 2:04 P.M., DM #50 terminated DA #51's employment by phone due to resident abuse.</p> <p>On 04/23/26, the Resident Care Coordinator (RCC) began staff education on deescalation techniques titled Resident Aggression: Understanding and Managing Difficult Behaviors with education completed on 04/24/26. Any employee not receiving all education by this date will receive prior to next scheduled shift.</p> <p>On 04/24/26, the Administrator finalized the SRI involving DA #51 towards Resident #4. The facility substantiated DA #51 had physically abused Resident #4.</p> <p>Although the Immediate Jeopardy was removed on 04/24/26, the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as (continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>the facility was in the process of implementing their corrective action plan and were monitoring to ensure ongoing compliance.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #4 revealed an admission date of 01/11/26 with diagnoses including anoxic brain damage, acute and chronic respiratory failure, anxiety disorder, viral hepatitis C, schizoaffective disorder, and cerebral infarction.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #4 dated 01/22/26 revealed the resident was cognitively intact and required supervision of staff with activities of daily living (ADL).</p> <p>Review of the care plan for Resident #4 dated 01/22/26 revealed the resident had the potential for behavior problems related to noncompliance with care, treatment and medications, and at times would not adhere to safety measures. Resident #4 could be physically aggressive with staff. Interventions included the following: administer medications as ordered, allow resident to discuss feelings, approach and speak to the resident in a calm voice, attempt non-pharmacological interventions specific to the resident when behaviors are identified, encourage resident to attend activities of choice, staff to anticipate resident's needs.</p> <p>Review of a progress note for Resident #4 dated 04/18/26 revealed Certified Nursing Assistant (CNA) #86 observed Resident #4 hit DA #51. CNA #86 saw DA #51 strike Resident #4. DA #51 was immediately removed from the floor. Resident #4 was bleeding from his mouth. The nurse provided first aid to Resident #4 and notified the appropriate parties of the incident.</p> <p>Review of a witness statement per CNA #86 revealed DA #51 came onto the secured unit to see what Resident #4 wanted and Resident #4 immediately hit DA #51 in the face.</p> <p>Review of the witness statement from CNA #10 revealed DA #51 stated he was going back on the unit to see what Resident #4 wanted, because DA #51 saw the resident tapping on the window to the secured unit. CNA#10 instructed DA #51 to stay off the unit because Resident #4's aide could assist him. CNA #10 then heard screaming and went to check on the resident. DA #51 reported to the CNA #10 that Resident #4 had hit him in the face and as a reflex, he hit Resident #4 back.</p> <p>Review of the witness statement from RN #71 revealed DA #51 stated he was going on the unit to see what Resident #4 wanted as he was tapping on the window. RN #71 told him not to go on the unit, but he went anyway. RN #71 reported three seconds later she heard CNA #86 screaming she so ran onto the unit and found Resident #4 bleeding from his nose and mouth.</p> <p>Review of a witness statement from DA #51 dated 04/18/26 at 11:15 A.M. revealed as he was taking (continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>assessment on Resident #4 and DM #50 came and removed DA #51 from the unit.</p> <p>During an interview on 04/28/26 at 1:18 P.M., DA #51 stated on 04/18/26 he entered the secured unit to take juice to another resident. Once he entered the unit, he noticed Resident #4 had money in his hand and offered to buy him a soda. DA #51 stated Resident #4 hit him immediately. DA #51 confirmed he then hit Resident #4 back as a reflex. DA #51 stated he then left the unit as directed and waited to talk to the police. DA #51 confirmed he lost his job as a result of the incident.</p> <p>Review of the facility policy titled Abuse, Neglect, and Exploitation, undated, revealed abuse was defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment resulting physical harm, pain, or mental anguish. Physical abuse was defined as including but was not limited to hitting, slapping, punching, biting and kicking. Abuse also included controlling behavior through corporal punishment.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number 2989908 and Complaint Number 2988458 and Complaint Number 2977628 and Complaint Number 2988715.</p> | | |