

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/16/2026
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)		
F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on review of personnel files, staff interviews, and policy review, the facility failed to ensure employees were screened for history of abuse on the Ohio Abuse Registry. This had the potential to affect all residents. The facility census was 31. Findings include: Review of personnel files revealed files for the Administrator, the former Director of Nursing (DON) #400, the Admissions #76, the Human Resources (HR) #74, Certified Nursing Assistant (CNA) #32 and #34, and Registered Nurse (RN) #104 had no evidence the facility had screened the employees through the Ohio Abuse Registry. During an interview on 06/16/26 at 10:33 A.M. HR #74 verified personnel files contained no evidence of abuse registry checks. During an interview on 06/16/2026 at 1:15 P.M. the Administrator stated the former DON left abruptly and they were unable to locate the binder with evidence that staff were checked against the Ohio Abuse Registry. Review of policy titled Abuse, Neglect, and Exploitation dated 2025 revealed the facility screened potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property and maintained documentation of proof the screening had occurred.		

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of personnel files, staff interviews, and policy review, the facility failed to implement the abuse policy. This had the potential to affect all residents. The facility census was 31. Findings include: Review of personnel files revealed files for the Administrator, the former Director of Nursing (DON) #400, the Admissions #76, the Human Resources (HR)# 74, Certified Nursing Assistant (CNA) #32 and #34, and Registered Nurse (RN) #104 had no evidence the facility had screened employees through the Ohio Abuse Registry. During an interview on 06/16/26 at 10:33 A.M. HR #74 verified personnel files contained no evidence of abuse registry checks. During an interview on 06/16/26 at 1:15 P.M. the Administrator stated the former DON left abruptly and they were unable to locate the binder with evidence that staff were checked against the Ohio Abuse Registry. Review of policy titled Abuse, Neglect, and Exploitation dated 2025 revealed the facility developed and implemented written policies and procedures to prohibit and prevent abuse and provided ongoing oversight and supervision to ensure policies were implemented as written.		

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on personnel file review and interview, the facility failed to ensure the activity department was operated by a qualified activity professional. This had the potential to affect all residents. The facility census was 31. Findings include: Review of the personnel file revealed the Social Services Director (SSD) #64 was hired on 02/17/25. Shortly after hire the SSD #64 was given the role of Activity Director. Further review of the personnel file revealed no documentation related to qualifications for the position of Activity Director. Interview on 06/16/26 at 1:37 P.M. with SSD #64 revealed the position of Activity Director was added to her job duties after she was hired. SSD #64 verified she did not have any of the required qualifications for the position and was in the process of taking an online course to become certified. Interview on 06/16/26 at 1:51 P.M. with Human Resources Director (HRD) #74 revealed there was no documentation related to the change in position for SSD #64, which included the addition of the role of Activity Director. HRD #74 was unable to provide information related to the individual in the position of Activity Director prior to SSD #64.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review, interview, and policy review, the facility failed to have Registered Nurse (RN) coverage as required. This had the potential to affect all residents. The facility census was 31. Findings include: Review of the Payroll Based Journal Staffing Data Report for 10/01/25 to 12/31/25 revealed the facility triggered for failure to have RN coverage on 10/11/25 and 10/12/25. Review of the timecard punches for 10/01/25 to 12/31/25 revealed no evidence of RN coverage for 10/11/25 and 10/12/25. Interview on 06/16/26 at 12:40 P.M. with the Administrator verified the facility had no RN coverage on 10/11/25 and 10/12/25. Review of the facility policy titled Nursing Services-Registered Nurse (RN), undated revealed the facility would utilize the services of an RN for at least eight consecutive hours daily, seven days per week.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident and staff interview, and policy review, the facility failed to ensure food was served at the appropriate temperature. This had the potential to affect 30 of 30 residents in the facility who eat meals from the facility kitchen. The facility identified one resident (#05) who did not receive food from the kitchen. The facility census was 31. Findings include: Observation of a test tray on 06/15/26 at 8:52 A.M., after all trays had been delivered to residents, revealed the scrambled eggs were 107 degrees Fahrenheit (F) and the sausage links were 110 degrees F. Interview at the time of the observation the Dietary Manager (DM) #100 verified the temperature of the eggs was 107 degrees F and sausage was 110 degrees F. DM #100 stated the expectation was for food to be at least 130 degrees F when served to the residents. DM #100 tasted the eggs and confirmed they were not hot. Interview on 06/15/26 at 9:24 A.M., Resident #10 stated her breakfast that morning was not hot enough. Interview on 06/15/26 at 9:29 A.M., Resident #08 stated his breakfast that morning was not hot enough. Review of the facility policy titled, Record of Food Temperatures, dated 2023 revealed hot foods would be held at 135 degrees F.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to ensure food was stored in a manner to prevent the potential spread of foodborne illness. The facility also failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect 30 of 30 residents who receive food from the facility kitchen. The facility identified one resident (#05) who did not receive food from the kitchen. The facility census was 31. Findings include: 1. Observation on 06/14/26 at 8:34 A.M., upon surveyor entrance into the kitchen, revealed there was a drain on the floor below the ice machine and handwashing sink that was overflowing with standing water, measuring approximately two feet by 1 foot. After surveyor washed her hands the size of the puddle grew. Observation on 06/15/26 at 8:04 A.M. revealed the standing water below the handwashing sink extended approximately six feet across the floor and became larger when the surveyor washed her hands. Interview on 06/15/26 at 8:29 A.M., the Dietary Manager (DM) #100 verified the presence of the standing water on the floor by the ice machine and below the handwashing sink. DM #100 stated it had been that way for a long time because the drain needed to be cleaned out. 2. Observation on 06/14/26 at 8:37 A.M. revealed two bags of chicken, dated 05/30/26, in a pan sitting on a counter just outside the walk-in cooler. The chicken was warm to the touch. Interview on 06/14/26 at 8:52 A.M., the Dietary Aid (DA) #60 verified the chicken was stored on the counter and warm to the touch. The DA #60 stated the chicken was on the counter when she came into work at 6:45 A.M. that morning and she was the only one in the kitchen that morning. Interview on 06/14/26 at 12:17 P.M., the DM #100 stated the chicken was still sitting on the counter when she arrived and stated the chicken must have been set out the night prior and verified meat should not be thawed in such a manner. 3. Observation on 06/14/26 at 8:53 A.M. of the walk-in cooler revealed 10 pitchers of unidentified liquids sitting on a cart. There were no labels nor dates observed on any of the pitchers. Further observation revealed a bag of tortillas which was not sealed, and a plastic cup of grapes which was open to air and not labeled. Interview at the time of the observation, DA #60 verified the pitchers were not labeled nor dated. DA #60 stated the pitchers contained cranberry juice, lemonade, and fruit punch and were in the cooler already when she arrived earlier that morning. DA #60 verified the tortillas were not sealed and the plastic cup of grapes was open to air and not labeled. 4. Observation on 06/14/26 at 8:55 A.M. of the walk-in freezer revealed two boxes of hamburgers with the plastic bag inside opened and not sealed, and a box of ground beef with the plastic inside open and not sealed. Interview at the time of the observation, DA #60 verified the hamburgers and ground beef were not sealed properly. 5. Observation on 06/14/26 at 8:59 A.M. of the dry storage area revealed a large box of Styrofoam cups was stored directly on the floor. Further observation revealed an area, measuring approximately six inches, of a dark brown dried liquid with unidentifiable brown debris on the floor below the shelf. The entire dry storage area had visible dirt and grime throughout. Interview at the same time, DA #60 verified the Styrofoam cups were stored on the floor and should be stored at least six inches above the floor, the dark area of dried brown liquid, and the dirt and grime throughout the dry storage area. 6. Observations on 06/15/26 between 7:30 A.M. and 8:15 A.M. in the kitchen revealed: 1. Vents on both sides of the ice machine were coated in a fuzzy grey substance. 2. Pipes above the tray line and prep area were coated in a fuzzy grey substance. 3. Multiple areas of brown splatter on walls near the steamer and stove. 4. The floor below the stove and steamer had dried food/debris and heavy dark brown grime. 5. The outside of the plate warmer had brown splatters and grime buildup. 6. The area between the tray line assembly area and the shelf (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	below was coated in a brown grime-like substance. 7. There were crumbs, trash, and heavy dark brown grime throughout the kitchen around the edges of the floor. 8. There was a heavy coating of a grey fuzzy material on the grates of the juice machine. 9. There was brown buildup on the counter and wall behind the coffee maker. Interview on 06/15/26 at 8:55 A.M., DM #100 verified the ice machine and juice machine grates and vents were coated in a grey fuzzy material, the pipes above the tray line and prep area were coated in a grey fuzzy material, there were multiple areas of brown splatter, food debris, crumbs, and grime throughout the kitchen. DM #100 verified the entire kitchen was in need of deep cleaning. 7. Observation on 06/14/26 at 12:25 P.M. revealed Certified Nursing Assistant (CNA) #44 stood at the front of the 200 hall and poured fruit punch from a pitcher into approximately 10 Styrofoam cups and placed the cups on top of a tray on top of the cart of lunch trays. CNA #44 then pushed the cart of trays to the opposite end of the hall. The cups of fruit punch on the top of the cart were not covered. Interview on 06/14/26 at 12:26 P.M., CNA #44 verified the cups of fruit punch were not covered prior to pushing the cart to the opposite end of the hallway. CNA #44 stated there were no lids available to cover the cups of fruit punch. Review of the facility policy titled, Food Safety Requirements, dated 2026, revealed thawing food at room temperature was not acceptable. Meat should be refrigerated. Food should be labeled and dated, stored in a manner to prevent the deterioration or contamination of the food and should be kept in covered or tight containers. Dry food should be stored in a dry area off the floor. All foods should be covered when traveling a distance (i.e. down a hallway). Hands should be washed between contact with residents. Equipment should be clean.		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review, interview, and policy review, the facility failed to accurately submit staffing data in the Payroll Based Journal (PBJ) system. This had the potential to affect all residents. The facility census was 31. Findings include: Review of the PBJ Staffing Data Report for 10/01/25 to 12/31/25 revealed the facility triggered for failure to have licensed nursing coverage for 24 hours a day. Review of staffing data from 10/01/25 to 12/31/25 revealed the facility met the requirement for nursing coverage with the use of agency staff. Interview on 06/15/26 at 5:00 P.M. with the Administrator revealed agency hours were not submitted for the last quarter. Review of the undated facility policy titled Payroll Based Journal revealed the facility would timely submit complete and accurate direct care staffing information.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, interview, and policy review, the facility failed to ensure the Quality Assessment and Assurance (QAA) Committee met at least quarterly. This had the potential to affect all residents. The facility census was 31. Findings include: Review of the QAA Committee sign-in sheets for the last four quarters revealed no evidence of meetings prior to 04/29/26. Interview on 06/16/26 at 11:14 A.M. with the Director of Nursing (DON) verified there was no documentation of meetings prior to 04/29/26. Review of the undated facility policy titled Quality Assurance and Performance Improvement (QAPI) revealed the QAA Committee would meet quarterly.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the water management logs and plan, review of personnel files, observation, staff interview, and policy review, the facility failed to ensure appropriate hand hygiene was completed while passing meal trays and medications. The facility also failed to ensure enhanced barrier precautions were implemented as appropriate, legionella prevention measures were completed, and tuberculosis tests were administered to employees as planned. This had the potential to affect all 31 residents in the facility. Findings Included: 1. Observation on 06/14/26 at 12:28 P.M., Certified Nursing Assistant (CNA) #44 began to pass trays on the 200 hall. CNA #44 delivered trays to the rooms of Residents #20, #15, #01, and #24. CNA #44 did not perform hand hygiene at any time between passing each tray. A dispenser of hand sanitizer was observed on top of the cart of trays. On 06/14/26 at 12:29 P.M., CNA #44 delivered a tray to Resident #32, pulled him up in bed and assisted with tray setup. On 06/14/26 at 12:30 P.M., CNA #44 exited the room of Resident #32 and did not perform hand hygiene. CNA #44 then delivered trays to Residents #08 and #26. At 12:34 P.M., CNA #44 sanitized her hands for the first time during tray delivery on the 200 hall. Interview on 06/14/26 at 12:34 P.M., CNA #44 verified she had not sanitized her hands between each resident while passing trays, including after pulling Resident #32 up in bed. CNA #44 confirmed hand hygiene should be performed between each tray delivered. Continued observation on 06/14/26 at 12:37 P.M., CNA #44 delivered trays to Residents #12 and #10 and did not perform hand hygiene between passing the trays. Continued observation revealed CNA #44 began passing trays to the 300 hall residents at 12:40 P.M. CNA #44 delivered trays to Residents #04, #27, #28, #29, #06, and #25 and did not perform hand hygiene at any time during tray delivery on the 300 hall. Interview on 06/14/26 at 12:46 P.M., when queried, CNA #44 laughed and denied not performing hand hygiene while delivering the trays on the 300 hall. Interview on 06/16/26 at 11:49 A.M., the Director of Nursing (DON) stated she was unaware of the need to sanitize hands between the delivery of each tray, however verified hands should be sanitized after assisting residents with tray setup, including pulling the residents up in bed, and before passing the next tray. Review of the facility policy titled, Food Safety Requirements, dated 2026, revealed hands should be washed between contact with residents. 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included non-pressure chronic ulcer of the left foot, scute osteomyelitis of the right ankle and foot, type II diabetes, and acquired absence of the left leg below the knee. Review of the medical (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	utensils. CNA #38 reached into plastic bag and placed utensils on each tray and placed cups of red liquid on meal trays as she served trays to Resident #13, #18, and #22 who walked up to the meal cart. There was no hand sanitizer on cart, and CNA #38 did not sanitize hands between trays. CNA #38 closed the cart and pulled it down the hallway. CNA #38 placed pre-poured drinks on trays and retrieved plastic utensils out of the bag before delivering trays to Resident #23 and #7 who were in their rooms. CNA #38 did not sanitize or wash hands between residents. During an interview on 06/14/2026 at 12:44 P.M. CNA #38 verified she was responsible for pouring drinks and placing plastic utensils on the meal trays. She stated she poured a bunch of drinks and set them on the tray on top of the cart, uncovered, before she started passing the trays. She said she had not sanitized or washed her hands throughout the lunch service. She stated this was the only place she had ever worked where she had to put the utensils on the plate and stated Sometimes that bag gets sticky. 4. Review of the personnel files revealed the Administrator, the former DON #400, the Admissions #76, the Human Resources (HR) #74, and Certified Nursing Assistant (CNA) #32 had no evidence of a two-step Mantoux testing upon hire and CNA #34 had no evidence of Annual Tuberculosis (TB) screening of symptoms. During an interview on 06/16/26 at 10:24 A.M., the HR #74 verified the Administrator, the former DON #400, the Admissions #76, the Human Resources (HR) #74, and Certified Nursing Assistant (CNA) #32 had no evidence of two-step Mantoux testing upon hire and CNA #34 had no evidence of Annual Tuberculosis (TB) screening of symptoms. Review of facility TB Risk assessment dated [DATE] revealed healthcare workers received a two-step test upon hire and as needed. Test records were maintained in the employee file by Human Resources. Review of policy titled Infection Control & Tuberculosis Screening, undated revealed the facility screened all employees for TB infection after an offer was made but prior to the employee's duty assignment. The initial TB testing was a two-step test performed by injecting 5 Tuberculin units of purified protein derivative intradermally by a qualified health professional. If the reaction to the first test was negative, the facility administered a second test between seven to twenty-one days after the first test. The facility provided annual TB screening by screening all staff for symptoms. 5. Review of the medical record revealed Resident #5 was admitted on [DATE]. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, hypertension, dysphagia, anemia, depressive episodes and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. Resident #5's functional assessment revealed he was dependent for all Activities of Daily Living (ADL) and dependent for bed mobility, transfers, and wheelchair mobility. Review of the Electronic Health Record (EHR) on 06/14/26 at 4:00PM revealed Resident #5 had a physician's order for enhanced barrier precautions related to gastronomy tube (G-Tube). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 06/14/26 at 4:17 P.M. revealed Resident #5 had signage on his door announcing the resident was in enhanced barrier precautions (EBP). There was no cart with Personal Protective Equipment (PPE) outside the door. Observation on 06/15/26 at 9:00 A.M. revealed Registered Nurse (RN) #410 administered medications through the G-tube without wearing a gown. A cart with PPE had been placed outside of Resident #5's room at this time. Interview on 06/14/26 at 4:17 P.M. with the Director of Nursing (DON) verified no cart with PPE was present outside of Resident #5's door. Interview with RN #410 verified she administered medications through the G-tube of Resident #5 without having a gown on. Review of policy titled Enhanced Barrier Precautions, dated 2025 reveals to make gowns and gloves available immediately near or outside of resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. High-contact resident care activities include: device care or use, including feeding tubes. 6. Review of the form Testing and Monitoring of Water Management Plan for Legionella revealed there were no logs or documentation of water flushes being completed. Interview on 06/16/26 at 12:12 P.M., the Maintenance Director #78 verified the facility does not document water flushes in unoccupied rooms for Legionella prevention. Review of policy titled Legionella Surveillance, dated 2023 reveals in the absence of Legionella infections for a period of at least one year the facility shall implement primary prevention strategies. Review of the facility's Water Management Plan revealed there were only the last two pages of the plan in the Legionella binder. The plan had been signed by Maintenance Director #78. The plan revealed that stagnant water was a risk factor and that taps should be run in unoccupied rooms weekly.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on medical record review, observations, staff interviews and policy review, the facility failed to ensure medications were stored in a sanitary and secure manner and failed to properly dispose of expired medications. This had the potential to affect 20 residents who reside on the 200-300 halls. The facility census was 31. Findings include: 1. Observation on 06/15/26 at 8:53 A.M. at the Team One nurse's station revealed two medication cards each containing 30 Clozapine 50 mg pills for Resident #13 sitting out in an unlocked room on top of a wire rack holding hard charts. During an interview on 06/15/26 at 8:56 A.M. the Director of Nursing (DON) verified there were two pill cards for Resident #13 containing 60 Clozapine 50 mg tablets sitting on top of charts behind the nurse's station that were improperly stored and should have been locked in the medication room. 2. Observation of the Medication Cart One on 06/15/26 from 11:11 A.M. to 11:13 A.M. revealed there was one bottle of vitamin B12 100 microgram (mcg) tablets with an expiration date of 05/2026 in the top drawer. The middle drawers contained individual medication cards. Upon examination, four oblong orange tablets marked 512 (identified as empagliflozin) and one round blue tablet marked N559 (identified as L-methylfolate calcium) were observed out of the package in the bottom of the drawers underneath the medication cards. During an interview on 06/15/2026 at 11:18 A.M. Registered Nurse (RN) #11 verified the B12 tablets were expired and should have been discarded. RN #11 verified the four orange tablets and one round blue tablet were improperly stored and should have been discarded. 3. Observation on 06/15/26 at 11:22 A.M. in the Front medication room revealed two full bottles of B12 100 mcg 100 tablets with an expiration date of 05/2026 and two boxes Vapor action drops, 24 drops per box, with an expiration date of 03/2026. During an interview on 06/15/2026 at 11:26 A.M. RN #11 verified the throat drops and B12 tablets were expired and should have been thrown away. 4. Observation of the Medication Cart Three/Four on 06/15/26 at 11:27 A.M. revealed the top drawer contained nine ampules of Refresh Plus eye drop with an expiration date of 04/26 and one bottle of Thiamine B-1 100 mg marked as opened on 06/15/26 with an expiration dated of 02/26. The middle drawers contained individual medication cards. Upon examination, one tear-shaped, light yellow tablet marked TL and one round white tablet marked S-10n were found unpackaged in the bottom of the drawer under the medication cards. During an interview on 06/15/26 at 11:30 A.M. RN #410 verified B-1 100 mg tables were expired. RN #410 stated she had administered them this morning and had not checked the expiration date because it was labeled that it was opened 06/14/26 and she assumed it was good. RN #410 verified the two pills found in bottom of the middle drawer were not stored properly. During an interview on 06/16/26 at 11:13 AM the DON verified one resident (Resident #4) had active orders for B-1 100 mg, and two residents (Resident #5 and Resident #29) had active orders for Refresh Plus eye drops. There were no residents in the facility with active orders for B-12 100 mcg. Review of policy titled Medication Storage dated 2025 revealed all medications and biologicals were stored in locked compartments and the facility routinely inspected for discontinued and destroyed outdated medications according to policy.		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the weekly menu and diet spreadsheets, observation, staff and resident interviews, and policy review, the facility failed to provide drinks per resident preference. This affected four (Resident #4, #9, #10 and #35) out of 30 residents that received food trays. The facility census was 31. Findings Included: Review of the weekly menu week one provided upon request at entrance revealed coffee was listed as a menu item at all three meals every day. Review of the diet spreadsheets for 06/14/26 breakfast and lunch revealed coffee was listed at both meals. Observations of meal service in the kitchen on 06/14/26 between 8:25 A.M. and 8:45 A.M. and tray delivery on 06/14/26 between 12:25 P.M. and 12:45 P.M. revealed there was no coffee available to serve residents. Interview on 06/14/26 at 2:20 P.M. Resident #10 stated she liked to drink coffee with breakfast and did not have coffee with breakfast that morning. Interview on 06/14/26 at 2:21 P.M., Resident #09 stated she did not receive coffee with breakfast or lunch that day. Resident #09 stated she wanted coffee with every meal but often did not receive it as requested. Interview on 06/14/26 at 2:12 P.M., CNA #44 verified there was no coffee available at breakfast nor lunch. CNA #44 stated the coffee normally comes on top of the cart at breakfast. CNA #44 verified several residents asked for coffee and she told them it was not available. Interview on 06/14/26 at 2:26 P.M., the Dietary Manager (DM) #100 stated coffee was normally sent with breakfast trays but not with lunch and dinner. DM #100 stated coffee was served with activities at 11:00 A.M., 2:00 P.M., and 4:00 P.M., so coffee was not automatically sent with the trays, however if a resident wanted coffee, they could come to the dining room to get it. DM #100 verified the menus indicated coffee was listed as a menu item at all meals. Interview on 06/14/26 at 10:09 A.M., Resident # 4 prefers to have coffee with breakfast but had been told by staff for two weeks that there wasn't any coffee. Interview on 06/15/26 at 9:05 A.M. with Resident #35 revealed no coffee had been provided to her since she was admitted to the facility on [DATE]. Review of the facility policy titled, Food Preparation Guidelines, revealed menu items should be (continued on next page)		

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

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prepared following the facility's written menus and staff shall accommodate resident preferences. Drinks shall be provided consistent with resident needs and preferences.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure residents were treated with dignity and respect. This affected one (#02) out of four residents reviewed for dignity. The facility census was 31. Findings include: Review of the medical record for Resident #02 revealed an admission date of 09/04/18. Diagnoses included type two diabetes mellitus with diabetic polyneuropathy, aphasia following cerebral infarction, pseudobulbar affect, major depressive disorder, schizoaffective disorder, generalized anxiety disorder, and flaccid hemiplegia affecting right dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #02 was severely cognitively impaired. Resident #02 was assessed to require substantial/maximal assistance with eating, oral hygiene, and bed mobility, and was dependent for toileting, bathing, dressing, personal hygiene, and transfer. Observation on 06/14/26 at 9:59 A.M. revealed Resident #02 was sitting in bed with the breakfast tray on the overbed table. Certified Nurse Aide (CNA) #14 was standing up next to the overbed table and feeding Resident #02. Interview on 06/14/26 at 10:00 A.M. with CNA #14 revealed it was common practice for them to stand up while providing feeding assistance. Review of the facility policy titled Promoting/Maintaining Resident Dignity, undated revealed all staff were involved in providing care to residents to promote and maintain resident dignity. This deficiency represents non-compliance investigated under Complaint Number 3040887.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, and policy review, the facility failed to ensure residents had access to personal care products. This affected one (Resident #22) of five residents sampled for dignified care. The facility census was 31. Findings include: Review of the medical record revealed Resident #22 was admitted to the facility on [DATE]. Diagnoses included type II diabetes, chronic obstructive pulmonary disease, schizoaffective disorder - bipolar type, unspecified dementia, recurrent major depressive disorder, unspecified intellectual disabilities, human immunodeficiency virus, unspecified protein-calorie malnutrition, unspecified epilepsy, and unspecified anxiety disorder. Review of most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact, had no behaviors, did not wander, and did not reject care. Resident #22 required supervision for oral and personal hygiene. During an interview on 06/14/2026 at 11:00 A.M. Resident #22 stated he had issues getting razors and mouthwash. He stated the facility had been out of mouthwash for four days, and he had not shaved in four or five days. During an interview on 06/15/2026 at 12:10 P.M. Certified Nursing Assistant (CNA) #36 stated resident on the locked unit were not allowed to keep the mouthwash or razors in their rooms unsupervised. She stated there had never been a shortage of razors or mouthwash, but staff had to supervise residents on the men's unit while they used them. During an interview on 06/15/2026 at 12:12 P.M. CNA #34 stated Resident #22 asked for razors and mouthwash all the time. CNA #34 verified he told Resident #22 the facility didn't have any/were out of razors and mouthwash because Resident #22 drank the mouthwash, the CNA #34 did not want the resident cutting himself with a razor. CNA #34 stated as far as he knew, the facility had never had a shortage of razors or mouthwash. Review of policy titled Accommodation of Needs dated 2025 revealed the facility treated residents with dignity and respect and made reasonable accommodations for the individual needs and preferences of each resident.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on medical record review, document review, and staff interview, the facility failed to ensure residents with funds accounts had written authorizations in place. This affected two (#17 and #04) of four residents reviewed for funds. The facility identified 23 residents with current funds accounts. The facility census was 31. Findings include: 1. Review of the medical record of Resident #17 revealed an admission date of 02/09/24. Diagnoses included type II diabetes mellitus. Review of the Trust Account Balance list dated 06/15/26 revealed Resident #17 had an active funds account with the facility. The account balance was \$4380.75. Review of requested documents revealed Resident #17 did not have a signed authorization for his funds account. Interview on 06/16/26 at 10:25 A.M., Business Office Manager (BOM) #74 verified Resident #17 did not have a signed authorization for his funds account. 2. Review of the medical record of Resident #04 revealed an admission date of 02/14/25. Diagnoses included chronic obstructive pulmonary disease. Review of the Trust Account Balance list dated 06/15/26 revealed Resident #04 had an active funds account with the facility. The account balance was \$0.10. Review of the requested documents revealed Resident #04 did not have a signed authorization for his funds account. Interview on 06/16/26 at 10:25 A.M., BOM #74 verified Resident #04 did not have a signed authorization for her funds account.		

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on medical record review, document review, and staff interview, the facility failed to timely refund resident accounts. This affected one (#37) of one resident reviewed for closed funds accounts. The facility identified 23 residents with current funds accounts. The facility census was 31. Review of the medical record of Resident #37 revealed an admission date of 01/18/17. Diagnoses included paranoid schizophrenia. The resident discharged from the facility on 12/11/25. Review of the final resident trust fund check, dated 06/05/26, revealed the resident was refunded \$1770.86. Interview on 06/16/26 at 10:34 A.M., Business Office Manager (BOM) #74 verified Resident #37's account was not refunded until 06/05/26. BOM #74 stated, upon starting her position, she reviewed accounts and found the account had not yet been refunded. BOM #74 verified refunds should be issued within 30 days of discharge. Review of Resident #37's Management of Personal Funds authorization form, dated 12/07/21, revealed personal funds would be returned to the appropriate source within thirty days of discharge.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews and policy review, the facility failed to ensure baseline care plans addressed resident needs identified upon admission. This affected one (Resident #32) of three residents sampled for care planning. The facility census was 31. Findings include: Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. Diagnoses included wedge compression fracture of unspecified vertebra, unspecified dementia, repeated falls, type II diabetes, and unspecified anxiety disorder. Review of the minimum data set (MDS) assessment in progress started 06/11/26 revealed Resident #32 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Review of the admission nursing assessment dated [DATE] at 4:44 P.M. revealed Resident #32 had Moisture Associated Skin Damage (MASD) to buttocks. Review of a baseline care plan dated 06/08/26 revealed Resident #32 had no care plan related to current MASD or risk for pressure injury, had no care plan related to code status or advanced directives, and the dietary care plan was incomplete and was missing the resident's specific diet orders. Review of a progress note dated 06/11/26 revealed the nurse practitioner assessed Resident #32's skin and recommended treatment for Incontinence Associated Dermatitis (IAD) to bilateral buttocks including cleanse with wound cleanser or normal saline, applying Triad paste to base of the wound, leaving open to air, and changing every shift and as needed. Review of the electronic medical record revealed Resident #32 had no physician orders related to code status or the IAD treatment. During an interview on 06/15/26 at 8:48 A.M. the Director of Nursing (DON) verified Resident #32 had no baseline care plan for MASD or pressure injury risk, the dietary care plan was incomplete, and there was no care plan for code status or advanced directives. During an interview on 06/15/26 at 9:07 A.M. Licensed Practical Nurse (LPN) #70 stated upon admission, the nursing assessment populated to the baseline care plan. She stated if the nurse's filled out the assessment correctly, the care plan would reflect it. LPN #70 verified Resident #32 had no care plan for MASD with interventions for treatment or monitoring. LPN #70 verified Resident #32's dietary care plan was not completed accurately to reflect his current diet orders. Review of policy titled Baseline Care Plan dated 2025 revealed the facility developed a baseline care plan for each resident that included instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care. Interventions were initiated to address the resident's current needs including pressure injury risk and wound care.		

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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** Based on interview, record review, and policy review, the facility failed to ensure the care plan was revised for advance directives. This affected one (Resident #4) out of 16 residents reviewed for Advance Directive care planning. The facility census was 31. Findings Include: Review of the medical record revealed Resident #4 was admitted on [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), chronic diastolic heart failure, type II Diabetes Mellitus, major depressive disorder, unspecified asthma, and generalized muscle weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact as evidenced by Brief Interview for Mental Status score of 15. Functional abilities include set up assistance with oral hygiene and eating, moderate assistance toileting and bathing, supervision with dressing and grooming, supervision with bed mobility and transfers, and supervision with wheelchair mobility. Review of the electronic health record revealed Resident #4 had a physician's order dated 05/18/26 for Do Not Resuscitate (DNR). A hard copy of the advanced directive order form dated 05/18/26 was presented by the Director of Nursing (DON) revealed Resident #4 was Do Not Resuscitate Comfort Care (DNRCC). The plan of care completed on 05/20/26 revealed Resident #4 was care planned as a Full Code. Interview on 06/15/26 at 9:13 A.M. with the DON verified the most current care plan in the electronic health record does not match the advance directive ordered for Resident #4. Review of the Policy titled Residents' Rights Regarding Treatment and Advance Directives dated 2026 revealed during the care planning process, the facility will identify, clarify, and review with the resident or legal representative, whether they desire to make any changes related to any .Advance Directives. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. Any decision making regarding the residents choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interview, and policy review, the facility failed to ensure adequate activities of daily living (ADL) care was provided. This affected one (#10) of two residents reviewed for ADL care. The facility census was 31. Findings include: Review of the medical record of Resident #10 revealed an admission date of 04/11/27. Diagnoses included schizoaffective disorder, bipolar disorder, type 2 diabetes mellitus, peripheral vascular disease (PVD), and congestive heart failure (CHF). Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #10 had intact cognition. The resident required supervision with eating, bed mobility, and transfers, and partial/moderate assistance with bathing and personal hygiene. Review of the plan of care dated 06/30/25 revealed Resident #10 had an ADL self-care performance deficit related to CHF and PVD. Interventions included to provide assistance with bathing/showering. Observation on 06/14/26 at 11:01 A.M., Resident #10 had numerous hairs on her chin, measuring approximately one half inch in length. Interview at the time of the observation, Resident #10 stated she did not prefer to have chin hair. Interview on 06/14/26 at 11:02 A.M., Registered Nurse (RN) #09 verified Resident #10 had chin hair that needed shaved. Observation on 06/16/26 at 8:15 A.M., Resident #10 still had numerous chin hairs. Review of the facility policy titled Activities of Daily Living, dated 2025, revealed a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal hygiene.		

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NAME OF PROVIDER OR SUPPLIER Trotwood Health & Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4911 Covenant House Drive Dayton, OH 45426	
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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 medical record review, observation, and resident and staff interview, the facility failed to provide the care and services to treat edema. This affected one (#10) of one resident reviewed for edema. The facility census was 31. Findings include: Review of the medical record of Resident #10 revealed an admission date of 04/11/17. Diagnoses included schizoaffective disorder, bipolar disorder, type 2 diabetes mellitus, peripheral vascular disease, and congestive heart failure. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #10 had intact cognition. The resident required supervision with eating, bed mobility, and transfers, and partial/moderate assistance with bathing and personal hygiene. Review of the plan of care dated 06/30/25 revealed Resident #10 had an ADL self-care performance deficit related to her disease process. The resident was noted to require assistance with bathing/showering. Review of the physician orders revealed an order dated 02/06/26 to apply compression stockings every day shift. Interview on 06/14/26 at 11:02 A.M., Resident #10 stated nobody was applying her compression stockings. Observation on 06/14/26 at 12:09 P.M. revealed Resident #10 had edema in both legs and feet. The resident was wearing non-skid socks and the non skid sock was rolled down below the ankle, which revealed pitting edema. The resident was not wearing compression stockings. Review of the June 2026 treatment administration record (TAR) on 06/14/26 revealed Registered Nurse (RN) #15 signed off the compression stockings. Observation on 06/14/26 at 3:15 P.M. Resident #10 was not wearing compression stockings. Interview on 06/14/26 at 3:16 P.M., RN #15 verified Resident #10 was not wearing compression stockings. RN #15 further verified she had signed the TAR to indicate the compression stockings had been applied. Review of the June 2026 TAR on 06/15/26 revealed RN #11 signed off the compression stockings. Observation on 06/15/26 at 4:00 P.M., Resident #10 was not wearing compression stockings. Interview on 06/15/26 at 4:01 P.M., RN #11 verified Resident #10 was not wearing compression stockings. RN #11 further verified she had signed the TAR to indicate the compression stockings had been applied and signing the TAR should indicate the compression stockings had been applied.		

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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 medical record review, interviews, and policy review, the facility failed to implement orders for wound treatments. This affected one (Resident #32) out of one resident sampled for pressure injury prevention. The facility census was 31. Findings include: Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. Diagnoses included wedge compression fracture of unspecified vertebra, unspecified dementia, repeated falls, type II diabetes, and unspecified anxiety disorder. Review of the admission nursing assessment dated [DATE] at 4:44 PM revealed Resident #32 had Moisture Associated Skin Damage (MASD) to buttocks upon admission. Review of the care plan dated 06/08/26 revealed Resident #32 had no care plan related to current MASD or risk for pressure injury. Review of a wound assessment report dated 06/11/26 revealed Wound Nurse Practitioner (NP) #408 assessed Resident #32 for MASD wounds to the right and the left buttocks and wrote treatment orders to clean with wound cleanser, apply Triad paste, and leave open to air every shift and as needed. During an interview on 06/15/26 at 8:48 A.M. the Director of Nursing (DON) verified Resident #32 had no active treatment orders for MASD to bilateral buttocks. During a telephone interview 06/16/26 at 10:44 A.M., the Wound Nurse Practitioner (NP) #408 verified she completed wound rounds at the facility with an unidentified staff nurse on 06/11/26. Wound NP #408 stated she assessed and measured Resident #32's MASD to bilateral buttocks and provided verbal treatment orders to the nurse for the areas to be cleansed with wound cleanser, Triad paste applied to the wound bed, and left open to air every shift and as needed. Wound NP #408 stated the orders were also provided in her written wound assessment note that day. Wound NP #408 stated the expectation was that she provided verbal and written orders on the day of assessment and the facility staff entered the orders into the electronic record. Review of policy titled Pressure Injury Prevention and Management dated 2026 revealed the facility provided treatments and services to heal pressure injuries and to prevent infection and development of additional pressure injuries.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, and policy review, the facility failed to obtain a resident reweight timely. This affected two (Resident #02 and #17) out of three residents reviewed for nutrition. The facility census was 31. Findings include: 1. Review of the medical record for Resident #02 revealed an admission date of 09/04/18. Diagnoses included type two diabetes mellitus with diabetic polyneuropathy, aphasia following cerebral infarction, pseudobulbar affect, major depressive disorder, schizoaffective disorder, generalized anxiety disorder, and flaccid hemiplegia affecting right dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #02 was severely cognitively impaired. Resident #02 was assessed to require substantial/maximal assistance with eating, oral hygiene, and bed mobility, and was dependent for toileting, bathing, dressing, personal hygiene, and transfer. Review of the weights documented in the medical record revealed the last entry for Resident #02 was on 06/01/26. Review of the progress note dated 06/07/26 revealed Registered Dietician (RD) #412 recommended a reweight for Resident #02. Telephone interview on 06/15/26 at 2:51 P.M. with RD #412 revealed she did not have any documentation related to a reweight for Resident #02. Interview on 06/16/26 at 11:47 A.M. with the Director of Nursing (DON) revealed no reweight had been completed for Resident #02 because the facility was not aware of the recommendation that had been documented in the progress notes. 2. Review of the medical record for Resident #17 revealed an admission date of 02/09/24. Diagnoses included type two diabetes mellitus without complications, chronic obstructive pulmonary disease, hypertension, chronic respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hyperlipidemia, dysthymic disorder, encephalopathy, hypo-osmolality and hyponatremia, syncope and collapse, and pure hypercholesterolemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was severely cognitively impaired. Resident #17 was assessed to require supervision for eating and bed mobility, partial/moderate assistance for oral hygiene, upper body dressing, and transfer, and substantial/maximal assistance for toileting, bathing, lower body dressing, and personal hygiene. Review of the weights documented in the medical record for Resident #17 revealed the last entry was on 06/01/26. Review of the progress note dated 06/07/26 revealed RD #412 recommended a reweight for Resident #17. Telephone interview on 06/15/26 at 2:51 P.M. with RD #412 revealed she did not have any documentation related to a reweight for Resident #17. Interview on 06/16/26 at 11:47 A.M. with the DON revealed no reweight had been completed for Resident #17 because the facility was not aware of the recommendation that had been documented in the progress notes. Review of the facility policy titled Weight Monitoring, undated revealed the facility would ensure all residents maintained acceptable parameters of nutritional status.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review, the facility failed to ensure diabetic medication was administered as ordered. This affected one (Resident#3) of five residents sampled for pharmacy services. The facility census was 31. Findings include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included non-pressure chronic ulcer of the left foot, scute osteomyelitis of the right ankle and foot, type II diabetes, and acquired absence of the left leg below the knee. Review of the medical record revealed Resident #3 had physician orders dated 04/24/26 for Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject 13 units subcutaneously four times a day for diabetes mellitus. Observation on 06/14/26 at 8:55 A.M. revealed Registered Nurse (RN) #9 carried pills, insulin pen, pen needle, and alcohol swabs to Resident #3's room. As Resident #3 swallowed his oral medications, RN #9 dialed the insulin pen to 12 units, applied the pen needle, swabbed Resident #3's left upper arm and injected 12 units of lispro insulin. During an interview on 06/14/26 at 9:01 A.M. RN #9 verified she had only given 12 units of insulin to the patient and stated she was going to call the doctor to see if it was okay to give another unit of insulin. RN #9 verified the order was for 13 units of insulin. Review of policy titled Medication Administration dated 2026 revealed medications were administered by licensed personnel as ordered, in accordance with professional standards of practice and in a manner to prevent contamination or infection.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, staff interview, and policy review, the facility failed to ensure a comfortable environment with properly functioning equipment. This affected one (#12) of three residents reviewed for environment. The facility census was 31. Findings include: Observation on 06/14/26 at 9:14 A.M. revealed a large puddle of standing water, measuring approximately two by three feet, in the corner of Resident #12's room, below the air conditioning unit on the wall. Further observation revealed the air conditioning unit was actively dripping onto the floor. Interview on 06/14/26 at 9:43 A.M., Housekeepers #214 and #204 verified the standing water in Resident #12's room and the air conditioning unit was actively dripping water onto the floor. Observation on 06/14/26 at 12:01 P.M., the air conditioning unit continued active dripping into a trash can, which was now positioned below the unit. Review of the facility policy titled, Safe and Homelike Environment, dated 2025, revealed the facility would provide a safe, clean, and comfortable environment.		