STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365743	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wright Rehabilitation and Healthcare Center	829 Yellow Springs - Fairfield Rd Fairborn, OH 45324

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, witness statements, physician notes and staff interviews, the facility failed to prevent sexual abuse of one Resident (#11) of three reviewed. The facility census was 82. Findings include:1. Review of the medical record for Resident #11 revealed an admission date of 06/05/25. The resident was admitted with diagnoses including aphasia following stroke, paraplegia, anxiety and neuromuscular dysfunction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a Brief Interview Mental Status (BIMS) score of 15, indicating intact cognition. Resident #11 required set up for eating and was dependent for bed mobility, transfers, and toileting hygiene. Review of the progress note dated 11/11/25, written by Registered Nurse (RN) #111, revealed an unnamed Certified Nursing Assistant (CNA) alerted a female resident (Resident #10) was observed in Resident #11's room with her hand on his penis stroking up and down. Resident #11 was documented to inform the unnamed CNA he was awoken by the female resident and did not ask for it to happen. The residents were separated immediately. Review of the social service progress note dated 11/12/25 at 9:27 A.M. revealed the social worker spoke to Resident #11 and offered a telehealth visit from Company #1 and he agreed. Additional review of social service progress notes revealed on 11/12/25 at 12:53 P.M., social services offered a second service from Company #2 and Resident #11 agreed to this as well. The note further documented an unnamed counselor with Company #2 informed social services Resident #11 was feeling embarrassed and felt the incident was his fault.Review of the 11/21/25 psychiatric evaluation from Company #1 revealed Resident #11 reported a female resident was sexually inappropriate with him the previous evening. The residents were separated and the facility was monitoring the situation closely and he was pleased with that.Review of the written statement of RN #111 revealed CNA #103 informed RN #111, Resident #10 was in Resident #11's room, with her hand on his penis stroking up and down. The residents were separated, and Resident #10 was placed on one-on-one supervision. RN #111 interviewed Resident #11 who informed her he was awoken from his sleep by Resident #10 touching his penis, he stated he did not ask for it to happen, and he asked her to stop. Resident #10 stopped when CNA #103 entered the room.Review of the written statement of CNA #103 revealed while doing rounds, he observed Resident #10 go into Resident #11's room and CNA #103 observed Resident #10 stroking Resident #11's penis. Once CNA #103 was observed entering the room, Resident #10 immediately stopped and covered up Resident #11. Resident #10 was removed and returned to the Memory Support Unit (MSU).2. Review of the medical record for Resident #10 revealed admission date of 03/15/22. The resident was admitted with diagnoses including alcohol dependence with alcohol induced persisting dementia, stroke, aphasia following stroke, schizophrenia and Wernicke's encephalopathy. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had a BIMS score of 15 indicating intact cognition. She required set up assistance with eating, bed mobility, transfers, and toileting hygiene. Review of the care plan revealed Resident #10 was a supervised smoker, was an elopement risk, and had aggressive behaviors.Review of the progress note dated 11/11/25 at 8:45 P. M. RN #111 documented an unnamed CNA alerted her Resident #10 was observed in another resident's room (Resident #11) with her hand on his penis stroking up and down. Resident #11 asked Resident #10 to stop, and she did not stop until the staff member entered the room. The residents were separated immediately, and Resident #10 was placed on one-on-one supervision.Review of the progress note dated 11/12/25 at 1:57 P.M. revealed Resident #10 had a telehealth appointment with Company #1 regarding the recent sexual incident. Resident #10 agreed not to touch another resident inappropriately and monitoring would continue.Review of the 11/21/25 psychiatric evaluation from Company #1 revealed Resident #10 stated she and Resident #11 had been in a relationship but if he didn't want to date anymore, she would not bother him. She agreed not to touch Resident #11 if he did not want to be touched. The note documented staff had reported Resident #10 touched Resident #11 inappropriately and he did not want it to occur. Interview on 11/19/25 at 9:12 A.M. with Assistant Director of Nursing (ADON) #102 revealed staff reported Resident #10 was observed entering Resident #11's room by CNA #103. It was reported to ADON #102, CNA #103 witnessed inappropriate touching of Resident #11 and Resident #10 mirrored in the window. ADON #102 verified Resident #10 resided in MSU which he acknowledged was a locked unit. ADON #102 explained the incident occurred during a smoke break and ADON #102 explained Resident #10 reported she was cold, so staff permitted her to go back into the facility unsupervised, which allowed her the opportunity to

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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** Based on record review and staff interviews, the facility failed to ensure residents residing in a secure memory care unit were observed when outside the unit. This affected one Resident (#10) of three reviewed. The facility census was 82. Findings include:Review of the medical record for Resident #10 revealed admission date of 03/15/22. The resident was admitted with diagnoses including alcohol dependence with alcohol induced persisting dementia, stroke, aphasia following stroke, schizophrenia and Wernicke's encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. She required set up assistance with eating, bed mobility, transfers, and toileting hygiene.Review of the care plan revealed Resident #10 was a supervised smoker, was an elopement risk, and had aggressive behaviors.Review of the progress note dated 11/11/25 at 8:45 P.M., Registered Nurse (RN) #111 documented an unnamed Certified Nursing Assistant (CNA) alerted her Resident #10 was observed in another resident's room (Resident #11) with her hand on his penis stroking up and down. Resident #11 asked Resident #10 to stop, and she did not stop until the staff member entered the room. The residents were separated immediately, and Resident #10 was placed on one-on-one supervision.Interview on 11/19/25 at 9:12 A.M. with Assistant Director of Nursing (ADON) #102 revealed staff reported Resident #10 was observed entering Resident #11's room by CNA #103. ADON #102 verified Resident #10 resided in the Memory Support Unit (MSU), which he acknowledged was a locked unit. ADON #102 explained during a smoke break, Resident #10 reported she was cold, so staff allowed her to go back into the facility unsupervised, which allowed her the opportunity to enter Resident #11's room.Interview on 11/19/25 at 11:31 A.M. with Social Worker #110 revealed she was informed Resident #10 had entered Resident #11's room after she was left unattended by staff. She explained Resident #10 required the locked MSU due to her elopement risk.Interview on 11/19/25 at 12:36 P. M. with the Director of Nursing (DON) and Administrator revealed on 11/11/12 the DON was contacted by CNA #103 and informed he witnessed Resident #10 enter Resident #11's room. Upon investigation, it was discovered during the 8:30 P.M. smoke break on 11/11/25 Resident #10 informed Laundry Aid (LA) #112 she was cold and wanted to wait inside the activity room until smoke break was over. LA #112 agreed, and after smoke break when Resident #10 was not in the activity room it was assumed, she had gone back to the unit. The DON and Administrator each verified it was the expectation of the staff assigned to smoke breaks observe the MSU residents at all times until returned and secured back in the unit.