STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026

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 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 observations, staff interviews, and review of facility food safety policy, the facility failed to ensure food and food preparation services were protected from potential contamination. This had the potential to affect all residents in the facility that received food from the kitchen, except one resident (#95) with an active NPO (nothing by mouth) order during the survey. The facility census was 78. Findings include: 1. Observation on 03/02/26 at 10:50 A.M. revealed one red bucket and one green bucket stored on the floor of the kitchen at the end of the food service line, adjacent to the prep sink and juice machine. Both buckets were observed holding washcloths in liquid solutions. Interview on 03/02/26 at approximately 10:51 A.M. with Dietary Manager #259 revealed the buckets stored on the floor were for detergent and sanitizer solutions that hold washcloths used to wipe down kitchen equipment such as food prep counters. Further interview at this time revealed Dietary Manager #259 believed the floor was likely not the best storage location for washcloths/sanitizer solution intended to clean kitchen surfaces. Additional interview at this time revealed the buckets of sanitizer solution and washcloths are usually stored directly on the floor due to a limited amount of space in the kitchen. 2. Observation on 03/03/26 at 9:45 A.M. revealed one large bag of partially thawed raw chicken thighs sitting in the rinse compartment of the three-compartment sink, with no water running. Further observation at this time revealed signage posted each compartment of the sink that indicated the sink was intended for washing, rinsing, and sanitizing utensils as well as other food service equipment. Another observation at this time revealed kitchen utensils were soaking in sanitizer solution in the sanitize compartment of the sink, next to the rinse compartment that was holding the bag of raw chicken. Interview on 03/03/26 at 9:50 A.M. with Dietary Manager #259 revealed kitchen staff regularly use the three-compartment sink for thawing foods, as the prep sink nearest to the food service line has a spray nozzle attached to the faucet that does not allow for a continuous flow of water to thaw foods. Further interview at this time revealed Dietary Manager #259 acknowledged the three-compartment sink is intended for washing, rinsing, and sanitizing utensils and other food service equipment rather than thawing foods. Review of the facility policy titled The Four Acceptable Methods for Thawing Food revealed acceptable methods for thawing foods include in a refrigerator at a temperature of 41 degrees Fahrenheit or lower, thawing in a microwave oven, thawing by submerging food under running potable water at a temperature of 70 degrees Fahrenheit or lower, or thawing as part of the cooking process. 3. Observation on 03/05/26 at 10:55 A.M. revealed the inside of the ice machine located in the activities room was visibly dirty with brown debris accumulating on the inside of the ice machine while holding ice. Interview on 03/05/26 at 10:55 A.M. with Licensed Practical Nurse (LPN) #253 revealed the ice in the ice machine was used for residents, and the inside of the ice machine appeared visibly dirty despite monthly cleanings. The facility confirmed all residents in the facility receive food from the kitchen, except one resident (#95) who has an active NPO order.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026

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Wright Rehabilitation and Healthcare Center	829 Yellow Springs - Fairfield Rd Fairborn, OH 45324

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, staff interviews, and review of a facility recipe for pureed food, the facility failed to ensure pureed food was prepared to the proper consistency and texture before serving the food to residents. This had the potential to affect seven (#15, #17, #7, #21, #26, #43, and #61) residents identified by the facility with pureed texture dietary orders. The facility census was 78. Findings include: Observation on 03/04/26 at 10:20 A.M. revealed [NAME] #320 placed seven scoops of diced ham into a food processor, along with an unidentified amount of chicken broth to begin making the pureed ham entree for lunch service. Further observation at this time revealed [NAME] #320 added two spoons of powdered thickening additive to the food processor, after the cook asked to be handed a teaspoon to measure powdered thickening additive. Interview on 03/04/26 at 10:20 A.M. with [NAME] #320 revealed they were unsure of the exact amount of chicken broth they added in with the ham to start pureeing the food, they believed the amount of broth added was around one-half liquid cup. Further interview at this time with [NAME] #320 and Dietary Manager #259 verified that the spoon used for adding thickening additive was not a true teaspoon intended for measuring foods, rather it was a spoon like the kind that would be used as part of meal service for residents. Observation on 03/04/26 at approximately 10:23 A.M. revealed [NAME] #320 added two more spoons worth of powder food thickening additive to the food processor with the ham and chicken broth mix. Interview on 03/04/26 at 10:28 A.M. with [NAME] #320 revealed they were seeking an applesauce like smooth texture for the pureed ham, and the finished pureed ham should have no distinguishable pieces of ham remaining on the palate when tasting the puree. Further interview at this time revealed [NAME] #320 usually tastes the pureed foods they prepare in the kitchen to be able to ensure the food is at the proper consistency and texture prior to serving the food to residents. Observation of tasting the pureed ham on 03/04/26 at 10:31 A.M. revealed small pieces of ham were felt on the palate and with swallowing the food. Interview on 03/04/26 at 10:31 A.M. with [NAME] #320 revealed they could sense small pieces of ham remaining in the pureed ham mix when they tasted the food. Interview on 03/04/26 at 10:31 A.M. with Food Service Director #301 revealed the pureed ham texture did appear to be somewhat soupy, but they expected the pureed blend to thicken while being held in a hot holding unit before the puree was going to be served at lunch. Observation on 03/04/26 at 10:35 A.M. revealed [NAME] #320 placed the food back in the hot holding unit without ensuring the pureed ham was free of small pieces in the mixture. Observation of tasting the pureed ham again on 03/04/26 at 11:42 A.M. during lunch service revealed small pieces of ham were still detectable on the palate after the majority of the pureed ham had dissolved with swallowing the food. Interview on 03/04/26 at 11:44 A.M. with Food Service Director #301 revealed they could sense small pieces of ham remaining in their mouth after tasting the pureed ham. Further observation at this time revealed that the Food Service Director #301 wasn't sure if the remaining pieces they felt on their tongue was end pieces of rind/skin of the ham, though they did not believe any pureed ham with small pieces remaining had been served to residents yet. Observation on 03/04/26 at 11:46 A.M. revealed three Residents (#21, #17, and #43) had been served pureed ham for lunch. The facility confirmed there are seven (#15, #17, #7, #21, #26, #43, and #61) residents who have pureed texture dietary orders. Interview on 03/04/26 at 12:00 P.M. with Speech Language Pathologist (SLP) #302 revealed pureed food should not have any pieces left to chew, and when pureed food dissolves in a resident's mouth, there should not be any pieces of food left in their mouth. Interview on 03/04/26 at 12:20 P.M. with SLP #302 revealed they went and tried the pureed ham without surveyors present, although pureed hotdogs had been prepared in place of the pureed ham due to the remaining small pieces left in the ham. Interview at this time revealed SLP #302 believed the puree was acceptable, although there were still small particles in the pureed ham when they tasted it. Review of the facility provided recipe for Pureed Baked Ham (no date) revealed the consistency of (continued on next page)

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	365743	A. Building B. Wing	03/09/2026

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pureed ham should be checked consistently until the food product is smooth, lump free, and extremely thick.

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

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, and family interviews, the facility failed to provide a written notification of a room change. This affected one (#95) of one residents reviewed for room changes. The facility census was 78. Findings include: Record review for Resident #95 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: aphasia, vascular dementia, hallucinations, altered mental status, esophageal obstruction. Review of Minimum Data Set (MDS) admission assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 07. This resident was assessed to be dependent with all care. Resident has a feeding tube. Review of the care plan dated 02/25/26 revealed vascular dementia with mood disturbance, psychotic disturbance, and anxiety. Review of Resident #95's progress notes revealed there was no documentation regarding the resident being moved to a different room, family notification or a written notice was given. Interview on 03/05/26 at 1:25 P.M. with Director of Nursing (DON) and Administrator revealed facility decided to move Resident #95 to Memory Care Unit (MCU) due to wandering. Interview on 03/05/26 at 1:32 P.M. with Social Services (SS) #217 revealed SS #217 notified Resident #95's family around 7:30 A.M. to 8:00 A.M. of Resident #95 moving to the MCU due to wandering into other rooms in the last couple of days. Interview on 03/05/26 at 1:40 P.M. with Resident #95's daughter revealed she was notified by phone at 8:45 A.M. regarding Resident #95 moving to the MCU. Resident #95's daughter left the facility at 2:10 P.M. and stated she had not received a written notification of room change.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, family interview, staff interview, and facility policy, the facility failed to maintain a clean and home-like environment. This affected one (#93) of two residents review for the physical environment. The facility census was 78. Findings include: Record review for Resident #93 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: Calculus of bile duct with cholangitis or cholecystitis without obstructive, chronic obstructive pulmonary disease, sepsis and Alzheimer's disease. Review of Minimum Data Set (MDS) admission assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 07. MDS admission was in progress. Observation on 03/02/26 at 12:06 P.M. revealed a two-inch round pile of flower potted soil substance that stood one-inch high was under the middle of Resident #93's bed more towards to head of the bed. Three small spots were located under the bed in line with the large spot. One round dust ball under the wall heating system beside Resident #93's bed was found on the floor. Interview on 03/02/26 at time of finding with Resident #93's family revealed Resident #93's family had requested three times since admission to housekeeping for floor to be swept and floor was never swept. Resident #93's family stated, Housekeeping only comes in to get trash and clean the toilet ever since we have been here. Interview on 03/02/26 at 3:22 P.M. with Housekeeper #284 revealed rooms are to be cleaned daily by sweeping, taking trash out, and cleaning bathroom. Housekeeper #284 confirmed Resident #93's room needed swept. Interview on 03/04/26 at 1:11 P.M. with Housekeeper #292 revealed rooms are to be cleaned daily by sweeping, taking trash out, and cleaning bathroom. Housekeeper #292 confirmed Resident #93's room needed swept. Review of an undated facility policy Housekeeping/Environmental Services revealed cleaning scheduled are developed and implemented to assure that each area of our facility is maintained in a safe, clean and comfortable manner.

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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 and staff interview, the facility failed to provide assessments and monitoring of a resident who tested positive for Coronavirus Disease 2019 (COVID-19). This affected one (#92) of one residents reviewed for COVID-19. The facility census was 78. Findings include: Record review for Resident #92 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: encephalopathy, vascular dementia, chronic obstructive pulmonary disease, and bronchitis. Review of Minimum Data Set (MDS) admission assessment dated in progress revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 99. This resident was assessed to be bladder incontinent. Review of the care plan dated 02/28/26 revealed Resident #92 had COVID-19 with interventions which include lab/cultures/diagnostic testing as ordered and report results to physician. Review with resident the importance of good handwashing, assist as needed. Encourage fluids unless contraindicated, monitor and report to physician signs/symptoms of dehydration (poor skin turgor, dry mucous membranes, increased heart rate, sunken eyes, decreased urinary output, difficult breathing, hypotension). Monitor for elevated temperature. Droplet isolation precautions; wear full personal protective equipment (PPE) while providing direct care. Review of progress notes revealed Resident #92 tested positive for COVID-19 on 02/28/26 and placed in droplet isolation. Care plan was updated on 02/28/26 with an intervention to monitor for elevated temperature due to COVID-19. Tympanic temperatures for Resident #92 were 98.9 degrees Fahrenheit on 02/27/26 at 8:43 P.M. and 98.0 degrees Fahrenheit on 03/01/26. Further review of Resident #92's medical record revealed there was no daily or shift-by-shift monitoring related to symptoms of dehydration, for elevated temperatures and/or respiratory symptoms were completed.Interview on 03/04/26 at 3:36 P.M. with Administrator verified no symptom management was completed for Resident #92 who tested positive for COVID-19. Interview on 03/04/26 at 4:14 P.M. with Director of Nursing (DON) verified no symptom management was completed for Resident #92 who tested positive for COVID-19.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to complete a proper bed rail assessment, including measurements of the air mattress and obtaining proper consent. This affected one (#96) out of one residents reviewed for siderails. The facility census was 78. Findings include: Review of the medical record of Resident #96 revealed an admission date of 07/22/25 with diagnoses of unspecified intracapsular fracture of right femur, subsequent encounter for closed fracture with routine healing, spondylopathy in diseases classified elsewhere, cervical region, dysphagia, oropharyngeal phase, wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the care plan dated 08/19/25 revealed Resident #96 had activities of daily living (ADL) self-care performance deficit related to severe lower back pain, unsteadiness on feet, dementia, insomnia, L5 compression fracture, and closed sub-capital fracture of right femur with intervention of 1/2 siderail use for repositioning and bed mobility. Review of the 01/20/26 admission Bed Rail Evaluation revealed informed consent was obtained from Resident #96. Review of the End of PPS Part A Stay Minimum Data Set (MDS) dated [DATE] revealed Resident #96 had severe cognitive impairment and required substantial assistance with bed mobility. Review of the incident investigation on 02/04/26 for Resident #96 revealed resident was found lying up against the right side bedrail with light bruising noted to the right side of the neck. Resident was guarding the right side (rib area) and tenderness was present. Side rails were removed. Physician ordered stat x-rays for the ribs on the right side. Review of the x-rays completed on 02/05/26 revealed age indeterminate right rib fractures. Interview on 03/09/26 at 10:31 A.M. with Registered Nurse (RN) #257 confirmed Resident #96 was found laying up against the right siderail in her bed on 02/04/26 and was complaining of pain. Interview confirmed resident had notable bruising to the right side of her neck. The physician was notified and an x-ray was ordered. Interview also confirmed Resident #96 was unable to describe what happened due to resident had dementia. Interview on 03/09/26 at 12:14 P.M. with the Director of Nursing (DON) confirmed Resident #96 had a brief interview for mental status (BIMS) of 07, which means the Resident #96 has severe cognitive impairment. Interview with the DON confirmed the facility had Resident #96 sign a consent for siderails on 01/20/26 and she should not of signed consent due to severe cognitive impairment. The DON confirmed the facility did not do proper measurements on the air mattress. The DON confirmed Resident #96 was unable to describe what happened on 02/23/26 when she was found laying against the siderail on an air mattress. Review of the Use of Bed Rails policy, dated September 2022 revealed bed rails will be used when appropriate and after an assessment is completed. This deficiency represents non-compliance investigated under Complaint Number 2742722.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure residents did not receive unnecessary medications, when one resident received antibiotics without a an adequate indication for use. This affected one (#10) out of six residents reviewed for unnecessary medications. The facility census was 78. Findings include: Review of the medical record revealed an admission date of 03/11/22 with diagnoses of Alzheimer's disease with late onset, chronic kidney disease, stage 3, essential (primary) hypertension, anxiety disorder, and major depressive disorder, recurrent, severe with psychotic symptoms. Further review revealed Resident #10 did not have a diagnosis of or history of diverticulitis or diverticulosis. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had moderate cognitive impairment and was not on an antibiotic. Review of the physician's progress noted dated 02/27/26 revealed resident was lethargic and wanted to sleep a lot, medication reduction was ordered. There was no documentation of Resident #10 having diverticulitis or diverticulosis. Review of the nurses note dated 02/28/26 at 5:33 A.M. revealed Resident #10 complained of severe left abdominal pain during the night, physician contacted and ordered Augmentin 875/125 mg twice daily for seven (7) days for diverticulitis. Review of the physician order dated 02/28/26 revealed and order for Augmentin 875/125 mg every 12 hours for seven (7) days for diverticulitis. Review of the general note dated 03/02/26 at 12:03 P.M. revealed Resident #10 was seen by the physician who reviewed the abdominal x-rays and they were negative for diverticulitis. Review of the care plan dated 03/06/26 revealed resident has an infection and is on antibiotic for diverticulitis. Telephone call on 03/03/26 at 10:28 A.M with Resident #10's guardian, confirmed Resident #10 has never had a diagnosis of diverticulitis or diverticulosis. Interview on 03/04/26 at 8:25 A.M. with Licensed Practical Nurse (LPN) / Infection Preventionist (IP) #246 confirmed Resident #10 is on Amoxicillin-Pot Clavulanate Tablet 875-125 MG twice daily for diverticulitis for seven (7) days which started on 02/28/26. Interview also confirmed the physician ordered the antibiotic based on resident symptoms, not testing results. Interview also confirmed the physician was has not contacted to discontinue the antibiotic due to not having proper testing for diagnoses and use of the antibiotic. Interview on 03/09/26 at 2:21 P.M. with the Director of Nursing confirmed there is not a policy for discontinuing medications that do not have a proper diagnosis for use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy, the facility failed to ensure behaviors were documented in a resident's medical record. This affected one (#95) out of three residents reviewed for medical record documentation. The facility census was 78. Findings include: Record review for Resident #95 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: aphasia, vascular dementia, hallucinations, altered mental status, esophageal obstruction. Review of Minimum Data Set (MDS) admission assessment dated [DATE] revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 07. This resident was assessed to be dependent with all care. Resident has a feeding tube. Review of the care plan dated 02/25/26 revealed vascular dementia with mood disturbance, psychotic disturbance, and anxiety. Review of Resident #95's progress notes revealed there was no documentation regarding wandering events or behaviors, Interview on 03/02/26 at 4:11 P.M. with Certified Nursing Assistant (CNA) #239 revealed Licensed Practical Nurse (LPN) #220 brought Resident #95 from west hall to memory care on the day of admission due to behaviors and stated Resident #95 needed to be a one on one. Resident #95 was kicking, punching, slapping and trying to get out of wheelchair. Interview on 03/05/26 at 1:25 P.M. with Director of Nursing (DON) and Administrator revealed facility decided to move Resident #95 to Memory Care Unit (MCU) due to wandering into multiple female rooms and was scaring female residents early this morning. DON stated Resident #95 was hard to redirect. The DON and Administrator confirmed there was no documentation of wandering in Resident #95's medical record. Interview on 03/05/26 at 1:32 P.M. with Social Services (SS) #217 revealed SS #217 notified Resident #95's family around 7:30 A.M. to 8:00 A.M. of Resident #95 moving to MCU due to wandering into other rooms in the last couple of days. SS #217 confirmed Resident #95's behavior was not documented in the medical record. Interview on 03/05/26 at 2:50 A.M. with LPN #241 revealed Resident #95 wandered around the east unit, got out of his wheelchair and was touching a mechanical lift (Hoyer). LPN #241 suggested a wander guard to DON in the A.M. just for safety. Resident #95 did not exit seeking. LPN #241 confirmed Resident #95's behavior was not documented in the medical record. Review of undated facility policy Charting and Documentation revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medial record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.