

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Centerville Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 McEwen Road Dayton, OH 45459	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46613</p> <p>Based on medical record review, observation, staff and resident interviews, and policy review, the facility failed to provide care and services to ensure fingernails were trimmed and free of dirt and debris. This affected one (#30) out of three residents reviewed for Activities of Daily Living (ADL's). The facility census was 69.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #30 revealed an admission ate of 12/11/18 with medical diagnoses of multiple sclerosis (MS), joint contracture's, and dysphagia.</p> <p>Review of the medical record for Resident #30 revealed a quarterly Minimum Data Set (MDS) assessment, dated 09/27/24, which indicated Resident #30 was cognitively intact and was dependent for all activities of daily living (ADL's) and had limited ROM to one upper extremity.</p> <p>Review of the medical record for Resident #30 revealed documentation to support Resident #30 received a bath or shower on 11/11/24, 11/18/24, and 11/22/24 but did not contain documentation to support nail care was provided.</p> <p>Observation with interview on 11/25/24 at 1:27 P.M. of Resident #30 revealed his fingernails to bilateral hands were long, had jagged edges, and had dirt and debris under the fingernails. Resident #30 stated the facility staff do not cut his fingernails often.</p> <p>Interview on 11/25/24 at 1:30 P.M. with State tested Nursing Assistant (STNA) # 228 stated residents are to have their fingernails trimmed and cleaned on shower/bath daily. STNA #228 confirmed Resident #30's fingernails were long, had jagged edges, and had dirt and debris underneath the fingernails.</p> <p>Review of the facility policy titled, Activities of Daily Living (ADL), revised March 2018, stated residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL's. The policy stated care and services would be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care), mobility, elimination, and dining.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160055.</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record reviews, staff and resident interviews, and policy review, the facility failed to ensure splints/braces were applied as ordered. This affected two (#30 and #75) out of three residents reviewed for cares and services to prevent decline in range of motion (ROM). The facility census was 69.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #30 revealed an admission ate of 12/11/18 with medical diagnoses of multiple sclerosis (MS), joint contracture's, and dysphagia.</p> <p>Review of the medical record for Resident #30 revealed a quarterly Minimum Data Set (MDS) assessment, dated 09/27/24, which indicated Resident #30 was cognitively intact and was dependent for all activities of daily living (ADL's) and had limited ROM to one upper extremity.</p> <p>Review of the medical record for Resident #30 revealed a physician order dated 10/24/24 to apply left resting hand splint up to eight hours at night and to discontinue use with any redness or skin breakdown. The order was discontinued on 11/25/24.</p> <p>Review of the medical record for Resident #30 revealed no documentation to support the facility applied the left resting hand splint from 10/24/24 to 11/24/24.</p> <p>Review of the medical record for Resident #30 revealed a contracture/impaired functional ROM to left hand care plan, dated 11/24/24, with an intervention to place resting hand splint up to eight hours as tolerated.</p> <p>Interview on 11/25/24 at 1:27 P.M. with Resident #30 stated staff did not apply the resting hand splint nightly as ordered. Resident #30 confirmed he is dependent upon staff to apply the hand splint and denied further contracture of left hand.</p> <p>Interview on 11/25/24 at 2:00 P.M. with Regional Nurse Consultant (RNC) #260 confirmed the medical record for Resident #30 did not contain documentation to support the left hand splint was applied as ordered.</p> <p>2. Review of the medical record for Resident #75 revealed an admitted [DATE] with medical diagnoses of dementia with other behavioral disturbances, psychotic disorder with delusions, diabetes mellitus, and chronic kidney disease stage III. Review of the medical record for Resident #75 revealed a discharge date of [DATE].</p> <p>Review of the medical record for Resident #75 revealed a quarterly MDS assessment, dated 10/23/24, which indicated Resident #75 had severe cognitive impairment and required substantial/maximum staff assistance for oral hygiene, bathing, personal care, bed mobility, and transfers and was dependent for toileting.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #75 revealed an Occupational Therapy (OT) discharge summary, for treatment from 09/03/24 to 11/14/24, which stated Resident #14 tolerated passive ROM for placement of air bladder splints and Resident #75 left air bladder rolled hand splint and left air bladder rolled splint with wrist support in place for four hours. The OT note stated OT staff educated floor staff and provided therapy recommendation form for splint wear and management.</p> <p>Review of the medical record for Resident #75 revealed a physician order dated 11/14/24 for resident to wear right hand air bladder splint with wrist brace and left-hand air bladder splint up to eight hours at night as tolerated.</p> <p>Review of the medical record for Resident #75 revealed no documentation to support the facility applied the splints to Resident #75's bilateral hands as ordered from 11/14/24 to 11/17/24.</p> <p>Interview on 11/26/24 at 12:34 P.M. with RNC #260 confirmed the medical record for Resident #75 did not contain documentation to support the facility staff applied Resident #75's bilateral hand splints as ordered from 11/14/24 through 11/17/24.</p> <p>Interview on 11/26/24 at 3:19 P.M. with Director of Rehabilitation (DOR) #275 confirmed OT services were discontinued for Resident #75 on 11/14/24 and the floor staff were educated on proper application and to check skin integrity for Resident #75's bilateral hand splints. DOR #275 stated the facility nursing staff were responsible for application of Resident #75's bilateral hand splints as ordered effective 11/14/24.</p> <p>Review of the facility policy titled, Resident Mobility and ROM, revised July 2017, stated residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. The policy also stated will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160055.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on the medical record reviews, observations, staff and resident interviews, and policy review, the facility failed to ensure medications were administered as ordered resulting in two medications errors out of 28 opportunities or a 7.14 percent (%) medication error rate. This affected two (#50 and #62) out of three residents reviewed for medication administration. The facility census was 69.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #50 revealed an admitted [DATE] with medical diagnoses of atrial fibrillation, depression, congestive heart failure (CHF), moderate protein calorie malnutrition, and bipolar disorder.</p> <p>Review of the medical record for Resident #50 revealed an admission Minimum Data Set (MDS) assessment, dated 10/28/24, which indicated Resident #50 was cognitively intact and required supervision with transfers and toilet hygiene and was independent with bed mobility.</p> <p>Review of the medical record for Resident #50 revealed a physician order dated 11/22/24 for Ativan one milligram (mg) to give one tablet by mouth daily.</p> <p>Review of the medical record for Resident #50 revealed a Controlled Drug Record which indicated on 11/25/24 at 8:09 A.M. an Ativan 0.5 mg tablet was signed off for Resident #50.</p> <p>Observation on 11/25/24 at 8:00 A.M. revealed Registered Nurse (RN) #135 prepare medication for Resident #50's morning medication administration. The observation revealed RN #135 remove Ativan 0.5 milligram (mg) tablet from the locked medication cart and place in medication cup. RN #135 signed the removal of the Ativan 0.5 mg tablet from Resident #50's Drug Control Record. The observation revealed RN #135 administer the Ativan 0.5 mg tablet to Resident #50.</p> <p>Interview on 11/25/24 at 8:13 A.M. with RN #135 confirmed Resident #50's order for Ativan was 1 mg by mouth daily not 0.5 mg tablet by mouth daily. RN #135 confirmed she administered the wrong dose of Ativan to Resident #50.</p> <p>2. Review of the medial record for Resident #62 revealed an admitted [DATE] with medical diagnoses of atrial fibrillation, diabetes mellitus, Parkinson's disease, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the medical record for Resident #62 revealed an admission MDS assessment, dated 09/20/24, which indicated Resident #62 was cognitively intact and required supervision with toilet hygiene, bathing, transfers, and bed mobility.</p> <p>Review of the medical record for Resident #62 revealed a physician order dated 11/19/24 for Flovent inhalation aerosol 110 micrograms (mcg) per actuation breath activated powder (act) inhaler one puff orally two times per day.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 11/24/24 at 9:35 A.M. revealed Licensed Practical Nurse (LPN) #223 administer two puffs of the Flovent inhaler to Resident #62.</p> <p>Interview on 11/24/24 at 9:48 A.M. with LPN #223 confirmed she administered two puffs of Flovent inhaler to Resident #62 and not the one puff as per physician orders.</p> <p>Review of the facility policy titled, Administering oral medications, stated facility staff are to check the label on medication and confirm the medication name and dose with MAR, check the medication dose and re-check to confirm proper dose.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00160170 and OH00160055.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on observations, review of the facility pest control invoices, and staff and resident interviews, the facility failed to ensure effective pest control measures were in place. This had the potential to affect all 69 residents residing in the facility. The facility census was 69.</p> <p>Findings include:</p> <p>Interview on 11/24/24 at 7:49 A.M. with State tested Nursing Assistant (STNA) #170 confirmed she worked on the secure unit and stated she observed a cockroach in the dining area that morning. STNA #170 stated the cockroach crawled under the baseboard on the floor.</p> <p>Interviews on 11/24/24 between 9:45 A.M. to 10:36 A.M. with Licensed Practical Nurse (LPN) #199, #223, and #250 stated they have observed large insects and cockroaches in the facility hallways and on the secured unit within the past two weeks.</p> <p>Interview on 11/24/24 at 10:17 A.M. with Resident #43 stated he had observed insects and mice in his room. Resident #43 stated she hasn't seen a mouse recently but had seen beetles or large black insects from time to time.</p> <p>Observation with interview on 11/25/24 at 7:37 A.M. revealed a large brownish-black insect crawling up the door of empty resident room [ROOM NUMBER]. Interview with Dietary Aide #189 confirmed the large brownish-black insect crawling up the door on empty resident room [ROOM NUMBER].</p> <p>Interview on 11/25/24 at 7:46 A.M. with Registered Nurse (RN) #135 confirmed she had seen large black bugs in resident rooms and in the laundry room recently.</p> <p>Observation with interview on 11/25/24 at 7:56 A.M. revealed a large black insect crawling along the baseboard of the secured unit dining room floor. Interview with STNA #146 confirmed the large black insect on the secured unit dining room floor.</p> <p>Interview on 11/26/24 at 10:45 A.M. with Resident #06 confirmed she has seen large insects in her room and staff will take care of the bugs for her. Resident #06 stated she saw a mouse once in her room but that was over one month ago.</p> <p>Review of the facility pest control invoices from May 2024 to October 2024 revealed the facility received monthly pest control treatments to the perimeter of the building, common areas, and kitchen. Review of the pest control invoices revealed in July 2024, one resident room was treated for cockroaches.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00160170 and OH00160055.</p>		