STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365764	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Health and Rehab	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)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, resident interview, and policy interview, the facility failed to provide timely dental services for residents to obtain dentures. This affected one (Resident #53) of five residents sampled for dental services. The facility census was 81. Findings include: Review of the medical record revealed Resident # was admitted to the facility on [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), unspecified dementia, unspecified anxiety disorder, nicotine dependence, and unspecified, cerebral infarction. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition, had verbal and self-directed behaviors, occasionally rejected care, and did not wander. Resident #43 required partial assistance with bathing and was independent with setup assistance for other activities of daily living (ADL). Review of care plan dated 05/21/26 revealed Resident #43 had potential for oral/dental health problems related to edentulous status and refused to go to appointment scheduled to obtain dentures on 05/21/26. Interventions included administering medications as ordered, coordinating dental care services, providing oral care, and monitoring/reporting any signs of dental problems. Review of progress note dated 06/27/25 at 12:59 A.M. revealed Nurse Practitioner (NP) #245 assessed Resident #43 on 06/26/25. She noted Resident #43 had no new complaints but was waiting for dentures from two weeks ago and asked nursing to follow up with the dental clinic to acquire dentures. Review of progress note dated 06/30/25 at 11:27 A.M. revealed nursing had contacted the clinic to ask about dentures and was informed the dentures were not at the clinic yet, but the clinic would mail Resident #43's dentures to the facility upon delivery. They anticipated they would receive the dentures in 15 days. Review of progress note dated 07/01/25 at 12:59 A.M. revealed NP #245 saw Resident #43 on 06/30/25 and noted he was very concerned that he had still not received his dentures. NP #245 requested staff call the dental office regarding dentures. Review of progress noted dated 09/30/25 at 3:44 P.M. revealed Licensed Practical Nurse (LPN) #108 completed a quarterly MDS assessment and noted Resident #43 was edentulous and wanted to see a dentist regarding dentures. Per Social Services, Resident #43 was on the list to be seen. Review of progress note dated 11/19/25 at 12:59 A.M. revealed NP #245 saw Resident #43 on 11/18/2025 and noted he had recently seen the dentist and was in the process of getting dentures. Review of progress notes dated 04/04/26 at 12:59 A.M. revealed NP #245 saw Resident #43 on 04/03/26 and noted he anticipated receiving his dentures within four to six weeks and expressed happiness about this since he had been waiting a year for new teeth. Review of progress note dated 05/27/26 at 1:45 P.M. revealed the facility contacted the dental office to follow-up regarding the resident's dentures. The dental office manager reported the resident's dentures were complete and Resident #43 was scheduled to be seen for dental services on 06/10/26 at the facility. During an interview on 12/27/26 at 12:17 P.M., Resident #43 stated he had been trying for over a year to get dentures. He stated he already had impressions made, and had a dental appointment scheduled for next month. During an interview on 05/28/26 at 1:41 P.M., LPN #108 confirmed Resident #43 was edentulous and she was unsure of why he did not have dentures yet. She stated she reported his concerns for dentures to social services to follow-up. During an interview on (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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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/28/26 at 2:57 P.M., NP #245 stated when Resident #43 admitted he stated he had gone to a dental clinic through his old facility. This facility called the clinic multiple times, and they did not answer their phone and had no service to leave a message. This facility decided to re-start the process. NP #245 stated Resident #43 complained to her during monthly wellness visits that he did not have his teeth. She reported his concerns to social services. NP #245 confirmed Resident #43 was edentulous and still did not have dentures. She stated Resident #43 reported to her that impressions were made and he should be getting his dentures soon. Review of policy titled Dental Services dated December 2016 revealed routine dental services were provided to residents through community dentists to provide dental services. Social Service representatives assisted residents with dental appointments.This deficiency represents non-compliance investigated under Complaint Number 3017235.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview, and policy review, the facility failed to maintain professional standards of infection control during medication administration. This affected two (Residents #3 and #6) of three residents sampled for medication administration. The facility census was 81. Findings include: 1) Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included end stage renal disease with dependence on renal dialysis, type II diabetes, unspecified protein calorie malnutrition, chronic diastolic heart failure, and cirrhosis of the liver. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #3 was cognitively intact, had no behaviors, did not reject care, and did not wander. Review of the medical record revealed Resident #3 had physician orders for routine medications scheduled for morning administration including tamsulosin (used to treat urinary symptoms caused by an enlarged prostate [BPH]) 0.4 milligrams (mg), carvedilol (beta-blocker used to lower the heart's workload) 3.125 mg, clopidogrel (antiplatelet medication) bisulfate 75 mg, and sertraline (antidepressant) 100 mg. 2) Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type II diabetes, stage III chronic kidney disease, and unspecified vascular dementia. Review of the most recent MDS assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander. Review of the medical record revealed Resident #6 had physician orders for routine mediations scheduled for morning administration including Apixaban (anticoagulant) five mg, metoprolol succinate (beta blocker for heart) extended release (ER) 24 Hour 25 mg, Psyllium Fiber oral capsule, Cholecalciferol (vitamin D3) Oral Tablet 25 micrograms, gabapentin (treats nerve pain), Atorvastatin (cholesterol) 20 mg, amlodipine besylate (for blood pressure) 10mg, and Sertraline 100 mg.Observations made on 05/27/26 from 9:15 A.M. to 9:30 A.M., revealed Registered Nurse (RN) #146 prepared morning medications for Resident #3 including tamsulosin 0.4 mg, carvedilol 3.125 mg, clopidogrel 75 mg, and sertraline 100mg, and medications for Resident #6 including routine metoprolol ER 25 mg, gabapentin, atorvastatin 20 mg, amlodipine 10 mg, and sertraline 100 mg, by pushing the medications through the film tab into her hand and then dropping each medication from her hand into the pill cup. She poured over the counter medications including Resident #6's psyllium fiber oral capsule, cholecalciferol 25 micrograms, and as needed acetaminophen 325 mg into the lid of the bottle and transferred each pill to her hand before placing the pills in the medication cup.During an interview on 05/27/26 at 9:20 A.M., RN #146 confirmed she had touched the medications during administration. She further stated she worked at the hospital where you were not allowed to touch the medications, but at this type of facility, as long as the nurse sanitized her hands before starting medication pass and washed her hands with soap and water after every two residents, it was acceptable to touch medications unless it was something dangerous like finasteride or apixaban. Review of policy titled Medication Administration dated April 2019 revealed staff followed infection control procedures while administering medications.This deficiency represents non-compliance investigated under Complaint Number 2992788.