

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365789	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Sanctuary at Wilmington Place		STREET ADDRESS, CITY, STATE, ZIP CODE 264 Wilmington Avenue Dayton, OH 45420	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, staff interview, and policy review, the facility failed to notify the medical provider of resident seizure activity. This affected one (Resident #36) of three residents reviewed for notification of change in condition. The facility census was 57 residents. Findings include: Review of the medical record for Resident #36 revealed an admission date of 04/03/25 with diagnosis of epilepsy. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 06/12/26 revealed the resident was cognitively intact and dependent on staff assistance with activities of daily living (ADLs.) Review of the care plan for Resident #36 dated 04/17/25 revealed the resident was at risk for complications related to diagnosis of seizure disorder. Interventions included the following: document intensity, length of seizure and any other issues related to seizure activity, notify physician of seizure activity. Review of the progress note for Resident #36 dated 06/06/26 at 1:18 P.M. revealed nurse administered Ativan due the resident having a seizure. Review of the progress note for Resident #36 dated 06/06/26 at 1:58 P.M. revealed the Ativan was effective and the resident felt better but was still shaking. Review of the progress note for Resident #36 dated 06/07/26 at 4:47 P.M. revealed the nurse administered Ativan due to the resident having a seizure. Review of the progress notes for Resident #36 dated 06/06/26 and 06/07/26 revealed they did not include documentation of notification to the resident's medical provider of the resident's seizure activity. Interview on 07/23/26 at 10:54 A.M. with Regional MDS Nurse #78 confirmed there was no documentation of the provider being notified of Resident #36's seizure activity on 06/06/26 and 06/07/26. Review of the facility policy titled Notification of Changes dated 2025 revealed the facility must inform the resident, consult with the residents physician and or notify the resident's family member or legal representative when there is a change in resident condition.		

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 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. Based on medical record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure staff provided timely incontinence care for dependent residents. This affected one (Resident #51) of four residents reviewed for incontinence care. The facility census was 57 residents. Findings include: Review of the medical record for Resident #51 revealed an admission date of 03/24/24 with diagnoses including hemiplegia and hemiparesis, morbid obesity, and type two diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #51 dated 04/22/26 revealed the resident was cognitively intact and dependent on staff assistance for toileting and personal hygiene. Observation on 07/23/26 at 9:43 A.M. revealed Resident #51's call light being activated. Interview on 07/23/26 at 10:00 A.M. with Resident #51 confirmed she had activated her call light about 15 minutes ago because she needed assistance with incontinence care. Resident #51 stated she usually pressed the call light for assistance earlier than she needed it because it typically took a long time to get assistance. Observation on 07/23/26 at 10:11 A.M. revealed a staff member went into Resident #51's room and turned the light off. Interview on 07/23/26 at 10:20 A.M. with Resident #51 verified an aide entered her room and informed the resident they would be back soon to assist. Interview on 07/23/26 at 11:34 A.M. with the Administrator confirmed 10 to 15 minutes was an acceptable call light response time and anything over 30 minutes was too long. Interview on 07/23/26 at 1:24 P.M. with Resident #51 confirmed the staff assisted her with incontinence care at 10:36 A.M. Review of the policy titled Activities of Daily Living dated 2025 revealed care and services will be provided for the following, toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents noncompliance investigated under Complaint Number 3033989 and Complaint Number 3042923.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on medical record review, staff interview, and policy review, the facility failed to ensure laboratory services were completed as ordered by the physician. This affected one (Resident #36) of three residents reviewed for laboratory services. The facility census was 57 residents. Findings include: Review of the medical record for Resident #36 revealed an admission date of 04/03/25 with a diagnosis of epilepsy. Review of the Minimum Data Set (MDS) assessment for Resident #36 dated 06/12/26 revealed the resident was cognitively intact and was dependent on staff assistance for activities of daily living (ADLs.) Review of the physician's orders for Resident # 36 revealed orders dated 06/05/26 for phenobarbital level to be obtained every six months and an order for a thyroid stimulating hormone (TSH) level to be drawn every 12 months starting on 07/01/26. Review of the medical record for Resident #36 revealed the phenobarbital and TSH were not drawn or resulted in July 2026. Interview on 07/23/26 at 10:54 A.M. with Regional MDS Nurse #78 confirmed the TSH and phenobarbital labs were not completed for Resident #36 as ordered. Review of the facility policy titled Laboratory Services and Reporting dated 08/01/25, revealed the facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The facility must provide or obtain laboratory services to meet the needs of its residents. The facility was responsible for the timeliness of the services.		