

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE 789 Stoneybrook Trail 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, resident interview, staff interview, review of facility Self-Reported Incidents (SRIs) and review of the facility policy, the facility failed to ensure residents were free from abuse. This affected one (Resident (#17) of three residents reviewed for abuse. The facility census was 84 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #17 revealed an admission date of 12/24/24 with diagnoses including chronic respiratory failure and failure to thrive.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #17 dated 12/30/24 revealed the resident had intact cognition and was dependent on staff for bathing.</p> <p>Review of the care plan for Resident #17 dated 03/06/25 revealed the resident had an ADL (activities of daily living) deficit related to altered respiratory status, deconditioning, and decreased endurance and frequently refused showers. Interventions included permission to receive a shower at any time of choice.</p> <p>Review of the SRI for Resident #17 dated 03/03/25 revealed Resident #44 reported to the Director of Nursing (DON) that on nightshift on 02/28/25 Certified Nursing Assistant (CNA) #370 forced Resident #17 to take a shower. Resident #44 confirmed Resident #17 screamed in protest, but CNA #370 ignored the resident, transferred the resident into a shower chair using a Hoyer lift, and wheeled the resident to the shower room with the resident screaming as the aide pushed the resident down the hallway. Interview with Resident #17 confirmed on 02/28/25 on night shift she told CNA #370 she did not want a shower, that it was illegal for the aide to touch her against her will, but the aide forced her to take a shower. Interview with CNA #300 who was also assigned to the unit confirmed on 02/28/25 he heard yelling found Resident #17 up in the shower chair and very angry. Interview with Registered Nurse (RN) #305 confirmed she heard screaming and went to Resident #17's room and found CNA #370 attempting to get Resident #17 out of bed and into the shower chair while the resident loudly refused. RN #305 confirmed she told CNA #370 to lay the resident back down, but the aide said the resident was already up and the aide wanted to get the shower done. The facility substantiated the allegation of abuse and terminated CNA #370.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE 789 Stoneybrook Trail 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/02/25 at 10:08 A.M. with Resident #44 confirmed her previous roommate Resident #17 was screaming at staff and refusing to take a shower a few nights ago. Resident #44 stated the aide forced Resident #17 to take a shower.</p> <p>Interview on 06/02/25 at 10:14 A.M. with Resident #17 confirmed CNA #370 had forced her to take a shower on 02/28/25 and she was very upset at the time and did not want to take a shower. Resident #17 further stated CNA #300 and RN #305 were present at the time, but were not listening to her, and did not stop CNA #370 from forcibly giving the shower.</p> <p>Interview on 06/02/25 at 12:08 PM with CNA #300 confirmed he was at the nurses' station on 02/28/25 when he heard yelling coming from Resident #17's room. CNA #300 and RN #305 went to see where the commotion was coming from and entered Resident #17's room. CNA #300 stated he saw Resident #17 in the Hoyer lift yelling at CNA #370 because she didn't want to take a shower. CNA #300 and RN #305 helped lower Resident #17 into the shower chair for safety and then left the room. CNA #300 confirmed he did not report the incident to management.</p> <p>Interview on 06/02/25 at 12:48 PM with RN #305 confirmed on 02/28/25 she heard yelling coming from Resident #17's room so she and CNA #300 went to the room and observed Resident #17 in the Hoyer lift yelling at CNA #370 because she did not want to take a shower. RN #305 stated did not intervene with the situation other than to help lower Resident #17 into the shower chair and then left the scene. RN #305 confirmed she did not report the incident to management.</p> <p>Interview on 06/02/25 at 3:05 PM with the Administrator confirmed Resident #44 notified the Assistant Director of Nursing (ADON) on 03/03/25 of an allegation of abuse towards Resident #17 per CNA #370 which had occurred on 02/28/25. The Administrator confirmed staff members should have reported the incident on 02/28/25 when it occurred. The Administrator confirmed the facility substantiated the allegation of abuse towards Resident #17 per CNA #370 and terminated the aides' employment.</p> <p>.</p> <p>Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 01/25/25 revealed residents have the right to be free from abuse. Staff should immediately report all incidents/ allegations to the Administrator who should make notifications to appropriate state reporting agency.</p> <p>Review of the facility's corrective action plan, completed by the Administrator, revealed the following actions were implemented and the deficiency corrected as of 04/04/25:</p> <p>&bull;</p> <p>There had been no other allegations of abuse per staff towards residents since the SRI dated 03/03/25.</p> <p>&bull;</p> <p>On 03/03/25 the Administrator suspended CNA #370 pending investigation.</p> <p>&bull;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE 789 Stoneybrook Trail 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/03/25 the Administrator and the DON terminated CNA #370's employment and was terminated on 03/03/25 and the facility reported CNA #370 to the nurse aide registry (NAR.)</p> <p>&bull;</p> <p>On 03/03/25 the DON assessed Resident #17 for injury with none noted. The DON offered emotional support via Social Services/Spiritual Care and the resident declined.</p> <p>&bull;</p> <p>On or before 03/05/25 the Social Services Director (SSD) interviewed all interviewable residents on Resident #17's hall to identify other care concerns with no concerns identified.</p> <p>&bull;</p> <p>On or before 03/05/25, the DON and unit managers conducted skin assessments on all non-interviewable residents on or before 03/05/25 with no abnormal findings.</p> <p>&bull;</p> <p>On or before 03/05/25 the DON/designee educated all staff on the abuse policy, including requirements for reporting abuse.</p> <p>&bull;</p> <p>Starting on 03/05/25 the DON designee started conducting the following audits:</p> <p>Interview two staff members daily for two weeks, then twice weekly for two weeks regarding resident rights/abuse</p> <p>Interview two residents daily for two weeks, then twice weekly for two weeks about care concerns.</p> <p>Observe direct care being delivered twice daily for two weeks and then twice weekly for two weeks to ensure proper delivery.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00163421 and Complaint Number OH00163350.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE 789 Stoneybrook Trail 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, resident interview, staff interview, review of facility Self-Reported Incidents (SRIs) and review of the facility policy, the facility failed to ensure allegations of abuse were reported immediately to the state agency. This affected one (Resident #17) of three residents reviewed for abuse. The facility census was 84 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #17 revealed an admission date of 12/24/24 with diagnoses including chronic respiratory failure and failure to thrive.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #17 dated 12/30/24 revealed the resident had intact cognition and was dependent on staff for bathing.</p> <p>Review of the care plan for Resident #17 dated 03/06/25 revealed the resident had an ADL (activities of daily living) deficit related to altered respiratory status, deconditioning, and decreased endurance and frequently refused showers. Interventions included permission to receive a shower at any time of choice.</p> <p>Review of the SRI for Resident #17 dated 03/03/25 revealed Resident #44 reported to the Director of Nursing (DON) that on nightshift on 02/28/25 Certified Nursing Assistant (CNA) #370 forced Resident #17 to take a shower. Resident #44 confirmed Resident #17 screamed in protest, but CNA #370 ignored the resident, transferred the resident into a shower chair using a Hoyer lift, and wheeled the resident to the shower room with the resident screaming as the aide pushed the resident down the hallway. Interview with Resident #17 confirmed on 02/28/25 on night shift she told CNA #370 she did not want a shower, that it was illegal for the aide to touch her against her will, but the aide forced her to take a shower. Interview with CNA #300 who was also assigned to the unit confirmed on 02/28/25 he heard yelling found Resident #17 up in the shower chair and very angry. Interview with Registered Nurse (RN) #305 confirmed she heard screaming and went to Resident #17's room and found CNA #370 attempting to get Resident #17 out of bed and into the shower chair while the resident loudly refused. RN #305 confirmed she told CNA #370 to lay the resident back down, but the aide said the resident was already up and the aide wanted to get the shower done. The facility substantiated the allegation of abuse and terminated CNA #370.</p> <p>Interview on 06/02/25 at 10:08 A.M. with Resident #44 confirmed her previous roommate Resident #17 was screaming at staff and refusing to take a shower a few nights ago. Resident #44 stated the aide forced Resident #17 to take a shower.</p> <p>Interview on 06/02/25 at 10:14 A.M. with Resident #17 confirmed CNA #370 had forced her to take a shower on 02/28/25 and she was very upset at the time and did not want to take a shower. Resident #17 further stated CNA #300 and RN #305 were present at the time, but were not listening to her, and did not stop CNA #370 from forcibly giving the shower.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE 789 Stoneybrook Trail 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/02/25 at 12:08 PM with CNA #300 confirmed he was at the nurses' station on 02/28/25 when he heard yelling coming from Resident #17's room. CNA #300 and RN #305 went to see where the commotion was coming from and entered Resident #17's room. CNA #300 stated he saw Resident #17 in the Hoyer lift yelling at CNA #370 because she didn't want to take a shower. CNA #300 and RN #305 helped lower Resident #17 into the shower chair for safety and then left the room. CNA #300 confirmed he did not report the incident to management.</p> <p>Interview on 06/02/25 at 12:48 PM with RN #305 confirmed on 02/28/25 she heard yelling coming from Resident #17's room so she and CNA #300 went to the room and observed Resident #17 in the Hoyer lift yelling at CNA #370 because she did not want to take a shower. RN #305 stated did not intervene with the situation other than to help lower Resident #17 into the shower chair and then left the scene. RN #305 confirmed she did not report the incident to management.</p> <p>Interview on 06/02/25 at 3:05 PM with the Administrator confirmed Resident #44 notified the Assistant Director of Nursing (ADON) on 03/03/25 of an allegation of abuse towards Resident #17 per CNA #370 which had occurred on 02/28/25. The Administrator confirmed staff members should have reported the incident on 02/28/25 when it occurred. The Administrator confirmed the facility substantiated the allegation of abuse towards Resident #17 per CNA #370 and terminated the aides' employment.</p> <p>Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 01/25/25 revealed residents have the right to be free from abuse. Staff should immediately report all incidents/ allegations to the Administrator who should make notifications to appropriate state reporting agency.</p> <p>Review of the facility's corrective action plan, completed by the Administrator, revealed the following actions were implemented and the deficiency corrected as of 04/04/25:</p> <p>&bull;</p> <p>There had been no other allegations of abuse per staff towards residents since the SRI dated 03/03/25.</p> <p>&bull;</p> <p>On 03/03/25 the Administrator suspended CNA #370 pending investigation</p> <p>&bull;</p> <p>On 03/03/25 the Administrator and the DON terminated CNA #370's employment and was terminated on 03/03/25 and the facility reported CNA #370 to the nurse aide registry (NAR.)</p> <p>&bull;</p> <p>On 03/03/25 the DON assessed Resident #17 for injury with none noted. The DON offered emotional support via Social Services/Spiritual Care and the resident declined.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE 789 Stoneybrook Trail 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&bull;</p> <p>On or before 03/05/25 the Social Services Director (SSD) interviewed all interviewable residents on Resident #17's hall to identify other care concerns with no concerns identified.</p> <p>&bull;</p> <p>On or before 03/05/25, the DON and unit managers conducted skin assessments on all non-interviewable residents on or before 03/05/25 with no abnormal findings.</p> <p>&bull;</p> <p>On or before 03/05/25 the DON/designee educated all staff on the abuse policy, including requirements for reporting abuse.</p> <p>&bull;</p> <p>Starting on 03/05/25 the DON designee started conducting the following audits:</p> <p>Interview two staff members daily for two weeks, then twice weekly for two weeks regarding resident rights/abuse</p> <p>Interview two residents daily for two weeks, then twice weekly for two weeks about care concerns.</p> <p>Observe direct care being delivered twice daily for two weeks and then twice weekly for two weeks to ensure proper delivery.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00163421 and Complaint Number OH00163350.</p>