

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  02/25/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080</b></p> <p>Based on record review, staff interview, facility protocol, and review of facility policy, the facility failed to notify the physician or the non-physician practitioner (NPP) for residents with change in conditions. This affected three Residents (#05, #70, and #71) reviewed for changes in condition. The facility census was 88.</p> <p>Findings Included:</p> <p>1) Review of medical record for Resident #05 revealed an admitted on 05/26/20. Diagnosis included obstructive hypertrophic cardiomyopathy, adult failure to thrive, Alzheimer's disease, chronic kidney disease stage two, orthostatic hypotension, essential hypertension, dementia, history of transient ischemic attack, and nonrheumatic aortic stenosis.</p> <p>Review of Resident #05's blood pressure monitoring revealed the following blood pressures documented:</p> <p>On 06/28/24 at 7:52 A.M., a blood pressure (B/P) reading of 185/77 (elevated) millimeters of mercury (mm/Hg) was recorded.</p> <p>On 06/28/24 at 7:52 A.M., a B/P 185/77 mm/Hg was recorded.</p> <p>On 07/15/24 at 8:41 A.M., a B/P 184/76 mm/Hg was recorded.</p> <p>On 09/02/24 at 8:00 A.M., a B /P 193/75 mm/Hg was recorded.</p> <p>On 09/08/24 at 9:48 A.M., a B/P 183/89 mm/Hg was recorded.</p> <p>On 09/24/24 at 7:28 A.M., a B/P 194/86 mm/Hg was recorded.</p> <p>On 09/29/24 at 7:17 A.M., a B/P 194/82 mm/Hg was recorded.</p> <p>On 09/30/24 at 7:18 A.M., a B/P 187/85 mm/Hg was recorded.</p> <p>On 10/11/24 at 8:30 A.M., a B/P 192/79 mm/Hg was recorded.</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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/14/24 at 7:21 A.M., a B/P 194/87 mm/Hg was recorded.</p> <p>Review of the nurse progress notes for Resident #05 from 06/28/24 through 10/14/24, revealed no documentation to support the physician or the NPP was notified when the resident's blood pressure was assessed to be elevated.</p> <p>Review of Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #05 had a Brief Interview of Mental Status (BIMS) of 01 which indicated severely cognitively impaired.</p> <p>Review of the plan of care dated 01/08/25 revealed that Resident #05 had altered cardiovascular status related to obstructive hypertrophic cardiomyopathy orthostatic hypotension, hypertension, and history of transient ischemic accident (TIA). Interventions included to monitor vital signs as needed, and notify the physician of significant abnormalities.</p> <p>Interview on 02/25/25 at 4:00 P.M. with Regional Clinical Nurse (RCN) #622, verified that there were no notifications to the physician or NPP when Resident #05's blood pressures were assessed to be elevated for aforementioned dates.</p> <p>Review of the facility protocol titled Standing Order Protocol dated November 204, revealed. If systolic blood pressure was above 180, staff should assess the resident for shortness of breath, chest pain, headaches, and visual changes and notify a physician.</p> <p>Review of facility policy titled Notification and Reporting of Changes in Health Status, Illness, Injury and Death of a Resident dated 12/27/23 revealed that if a resident had significant changes the provider, or its designees was to be notified no later than one business day. The provider was to be notified of significant change that may affect resident's service needs or safety, including any significant change in the individual's physical, mental, or emotional status. A notation of the change in health status and any interventions shall be documented in the medical record.</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48570</p> <p>Based on record review and staff interviews, the facility failed to issue an Advanced Beneficiary Notice (ABN) when a Notice of Medicare Non-Coverage (NOMNC) was issued to a resident under a Medicare stay and the resident did not discharge. This affected one Resident (#77) out of the three residents reviewed for ABN. The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #77 revealed an admitted [DATE] with diagnoses of acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease with acute exacerbation, and anemia.</p> <p>Review of the NOMNC indicated the last covered day was 01/07/25 and Resident #77 signed the NOMNC on 01/03/25.</p> <p>Review of the resident census information revealed Resident #77 was listed as private pay on 01/08/25 and 01/09/25.</p> <p>Review of the progress noted from 01/08/25 and 01/09/25 revealed no documentation that Resident #77 was notified of a last covered date (LCD) of 01/07/25 or the cost to remain in the facility.</p> <p>Review of the care plan for Resident #77 dated 01/13/25, revealed the resident planned to remain at the facility for long term care services and does not wish to be asked about returning to the community with every assessment.</p> <p>Interview on 02/24/25 at 9:03 A.M. with Business Office Manager (BOM) #592, confirmed Resident #77 received an LCD of 01/07/25 which was issued on 01/03/25 and an ABN or the cost to stay in the facility was not issued to Resident #77. BOM #592 stated the resident had initially planned to discharge home but then changed his mind. BOM #592 stated Resident #77 did end up being billed as private pay for 01/08/25 and 01/09/25 and then the resident applied for his veterans' benefits at that time. BOM #592 stated the facility does not have a policy on issuing an ABN.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on observation, staff interviews, record review, and review of a facility policy, the facility failed to maintain a clean and safe environment. This affected three Residents (#13, #64, and #08) out of three Residents reviewed for environment. The facility census was 88.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #13 revealed he was admitted to the facility on [DATE]. His diagnoses included anemia, heart failure, hypertension, ortho static hypertension, diabetes mellitus (DM), and aphasia.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #13 dated 01/28/25, revealed he had impaired cognition. Resident #13 was dependent on staff for activities of daily living (ADLs).</p> <p>Observation of Resident #13's room on 02/18/25 at 12:05 P.M. with Certified Nursing Assistant (CNA) 598, revealed the resident's bed had soiled sheets with stains and food crumbs all over it. The center of the mattress dipped inward. CNA #598 pulled the corner of the sheet off the mattress to reveal a severely worn mattress and sunken in the middle. The light switch was broken with sharp pieces sticking out. Interview with CNA #598 at the same time, verified Resident #13's bed and the broken wall plate.</p> <p>Interview with Resident #13 on 02/20/25 at 2:45 P.M., revealed he needed a new mattress via communication with a wipe off board. Resident #13 motioned with his hand that he needed to be pulled up in the bed. Resident #13 stated he needed to be pulled up in the bed because he slid down in the middle of the bed.</p> <p>Observation of Resident #13's room on 02/20/25 at 2:50 P.M. with CNA #511 revealed the resident's bed had active gnats flying around the bed with food crumbs and the bed appeared soiled. CNA #511 verified Resident #13 was sunken in the middle of the mattress and needed to be pulled up in the bed.</p> <p>Observation also revealed the windowsill was dirty with an unknown brown and green sticky substance. CNA #511 verified the window seal had an unknown brown and green sticky substance.</p> <p>2) Review of the medical record for Resident #64 revealed he was admitted to the facility on [DATE]. His diagnoses included dementia, schizoaffective disorder, depression, heart failure, gastro esophageal reflux disease (GERD), and essential primary hypertension.</p> <p>Review of the MDS assessment dated [DATE] for Resident #64 revealed he had mildly impaired cognition. Resident #64 was dependent on staff for ADLs.</p> <p>Observation of Resident #64's room on 02/18/25 at 10:23 A.M., revealed the bathroom floor had dust, other debris, an unknown brown chunky substance around the toilet and the floor appeared slippery. The toilet had a brown substance on/around the toilet. Interview at the same time with Resident #64, indicated he recently had a fall in his bathroom due to the floor being slick.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Housekeeper (HK) 583 on 02/18/25 at 10:28 A.M., verified Resident #64's bathroom floor was dusty, soiled, slippery and had an unknown chunky brown substance around the toilet. HK #583 verified the toilet was dirty and stated she was not in the facility the previous day and could not say when it had late been cleaned.</p> <p>3) Review of the medical record for Resident #08 revealed she was admitted to the facility on [DATE]. Her diagnoses included tachycardia, obstructive sleep apnea, epilepsy, impetigo, major depressive disorder, diffuse traumatic disorder, paraplegia, hereditary spastic paraplegia, anemia, chronic respiratory failure, and endometriosis.</p> <p>Review of MDS assessment, dated 11/01/25, revealed Resident#08 was cognitively intact and was dependent on staff for ADLs.</p> <p>Observation of Resident #08's room on 02/18/25 at 4:48 P.M. revealed a stick fly tray over her bed. Interview with Resident #08 at the same time revealed she asked the staff to hang the sticky fly strip on her ceiling over her bed several months ago because she had multiple large black flies swarming in her room.</p> <p>Interview with Licensed Practical Nurse (LPN) 564 on 02/18/25 at 5:30 P.M. verified the sticky fly strip hanging over Resident #08's with multiple large black flies stuck to it had been in place.</p> <p>Observation of Resident #08's room on 02/20/25 at 1:130 P.M. with Housekeeper (HK) #623 revealed the sticky flip strip with several dead large black flies remained hanging over Resident #08's bed. Interview with HK #623 verified the stick fly trap was hanging over the residents bed.</p> <p>Review of the facility policy titled, Routine Housekeeping Policy, dated 06/16/20, confirmed it the policy of this community to provide routine cleaning and disinfection in order to provide a safe, sanitary environment.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on record review and interview, the facility failed to complete a Pre Admission Screening and Resident Review (PASRR) following a significant change in residents' condition. This affected two Residents (#10 and #41) out of two residents reviewed for a PASRR. The facility census was 88.</p> <p>Findings Include:</p> <p>1) Review of the medical record for Resident #10 revealed she was admitted to 10/13/21. Her diagnoses included diabetes mellitus (DM), chronic obstructive pulmonary disease, hepatic failure, gastroparesis, contracture of muscle, schizophrenia, bipolar disorder, major depressive disorder, anxiety disorder, dementia, and pseudobulbar. Resident #10 was admitted to hospice care at the facility on 04/23/24. There was no correlating PASRR associated with the admission to Hospice.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #10 is cognitively impaired.</p> <p>Interview with the Social Worker (SW) #523 on 02/19/24 at 3:15 P.M., verified the facility failed to complete a Significant Change PASRR on 04/23/24, when Resident #10 was admitted to Hospice.</p> <p>2) Review of the medical record for Resident #41 revealed he was admitted to the facility on [DATE]. His diagnoses included, bradycardia, essential primary hypertension, atrial fibrillation, hyperlipidemia, obstructive sleep apnea, dementia, metabolic encephalopathy, and dysphagia. Resident #41 was admitted to hospice care at the facility on 11/05/24. There was no correlating PASRR associated with the admission to Hospice.</p> <p>Review of the MDS assessment, dated 02/05/25, revealed Resident #41 had impaired cognition.</p> <p>Interview with Regional Clinical Nurse (RCN) #622 on 02/20/25 at 4:47 P.M., verified the facility failed to complete a Significant Change PASRR review for Resident #41 when he was admitted to Hospice.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on observation, staff interviews, and record review, the facility failed to ensure residents were provided with quarterly care conferences. This affected two Residents (#08 and #64) out of the two residents reviewed for care conference. The facility census was 88.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #08 revealed she was admitted to the facility on [DATE]. Her diagnoses included tachycardia, obstructive sleep apnea, epilepsy, impetigo, major depressive disorder, diffuse traumatic disorder, anemia, chronic respiratory failure, and endometriosis.</p> <p>Review of the Inter Disciplinary Team (IDT) Care Conferences, revealed Resident #08 had care conferences on 09/13/24, and 01/21/25. The resident had no documented care conferences for the two remaining quarters of the past year.</p> <p>Review of Minimum Data Set (MDS) assessment, dated 11/01/25, revealed Resident #08 was cognitively intact and dependent on staff for activities of daily living (ADLs).</p> <p>Interview with Social Worker (SW) #523 on 02/19/25 at 2:40 P.M., verified Resident #08 did not have two of the four quarterly care conferences in the past year.</p> <p>2) Review of the medical record for Resident #64 revealed he was admitted to the facility on [DATE]. His diagnoses included dementia, schizoaffective disorder, depression, heart failure, gastro esophageal reflux disease (GERD), and essential primary hypertension.</p> <p>Review of the IDT Care Conferences dated 09/24/24 at 1:32 P.M. and 12/20/24 at 10:31 A.M. revealed Resident #64 and/or his representative(s) did not attend the care conferences. Further review of Resident #64's chart revealed no other information documentation related to any other care conferences for the past year.</p> <p>Review of the MDS assessment dated [DATE] for Resident #64, revealed he had mildly impaired cognition and was dependent on staff for ADLs.</p> <p>Interview Resident #64 on 02/18/25 at 10:20 A.M. revealed he did not recall having any care conferences.</p> <p>Interview with the SW #523 on 02/19/25 at 2:40 P.M. verified Resident #64 did not have quarterly scheduled care conferences for the past year.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>44080</p> <p>Based on record review, staff interview, and review of facility policy, the facility failed to ensure a resident's suprapubic urinary catheter was changed according to physician orders. This affected one Resident (#79) of the three residents review for foley catheters. The facility census was 88.</p> <p>Findings include:</p> <p>Review of medical record for Resident #79 revealed an admitted on 10/30/24. Diagnoses included dementia, hydronephrosis with renal and urethral calculous obstruction, calculus of gall bladder without obstruction, and chronic kidney failure.</p> <p>Review of admission Minimum Data Set (MDS) for Resident #79 dated 11/06/23, revealed he was severely cognitively impaired.</p> <p>Review of Resident #79's care plan dated 10/31/24, revealed Resident #79 had a suprapubic catheter related to obstructive uropathy. Interventions were to monitor for signs and symptoms of infection and change catheter as ordered and as needed.</p> <p>Review of a physician order dated 12/18/24, revealed Resident #79 was ordered to have the suprapubic catheter 14 French with 10 milliliter (mL) balloon changed every four weeks and as needed related to obstructive uropathy.</p> <p>Review of the January 2024 Treatment Administration Record (TAR) for Resident #79, revealed Resident #79 had his suprapubic urinary foley catheter changed on 01/15/25.</p> <p>Interview with the Director of Nursing (DON) on 02/19/25 at 2:20 P.M., revealed Resident #79's suprapubic urinary foley catheter change was due on 02/14/25; however, a new foley was not placed. The DON stated the nurse did not change the suprapubic urinary foley catheter as ordered and the nurse did not give a reason as to why she did not place a new suprapubic urinary catheter in Resident #79. The DON stated Resident #79 was prone to infections.</p> <p>Review of the February 2025 TAR revealed Resident #79 was due to have his suprapubic urinary foley catheter changed on Friday 02/14/25. The date was marked with a 9 which indicated other- see nurses notes. There was no corresponding progress note related to this entry on 02/14/25.</p> <p>Interview with Acting Administrator #799 on 02/25/25 at 5:20 P.M. revealed there was no policy on following physician's orders related to catheter care and the expectation was to follow standard nursing practices.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44080</p> <p>Based on record reviews, staff interviews, review of facility policy, and review of facility standing orders, the facility failed to ensure residents received medications as ordered. This affected one Resident (#05) of the five residents reviewed for medications. The facility census was 88.</p> <p>Findings include:</p> <p>Review of medical record for Resident #05 revealed an admitted on 05/26/20. Diagnosis included obstructive hypertrophic cardiomyopathy, adult failure to thrive, Alzheimer's disease, chronic kidney disease stage two, orthostatic hypotension, essential hypertension, dementia, history of transient ischemic attack, and nonrheumatic aortic stenosis. The resident was cognitively impaired.</p> <p>Review of a physician order for Resident #05 dated 09/04/24, revealed the resident was ordered Midodrine tablet five milligrams (mg) one tablet in the morning for hypotension (low blood pressure) and to hold for systolic blood pressure (B/P) above 120 millimeters of mercury (mm/Hg). The Midodrine was discontinued on 12/18/24.</p> <p>Review of plan of care dated 01/08/25, revealed that Resident #05 had altered cardiovascular status related to obstructive hypertrophic cardiomyopathy orthostatic hypotension, hypertension, and history of transient ischemic accident. Interventions included to administer medications as ordered, monitor vital signs as needed, and notify the physician of any significant abnormalities.</p> <p>Review of the April, May, June, July, August, September, October, November and December 2024 Medication Administration Records (MARs) for Resident #05 revealed the following:</p> <p>On 04/06/24, a B/P reading of 124/70 mm/Hg was recorded and Midodrine was administered.</p> <p>On 04/13/24, a B/P reading of 112/68 mm/Hg was recorded and Midodrine was held.</p> <p>On 04/14/24, a B/P reading of 116/68 mm/Hg was recorded and Midodrine was held.</p> <p>On 04/24/24, a B/P reading of 126/70 mm/Hg was recorded and Midodrine was administered.</p> <p>On 05/04/24, a B/P reading of 132/71 mm/Hg was recorded and Midodrine was administered.</p> <p>On 05/10/24, a B/P reading of 132/72 mm/Hg was recorded and Midodrine was administered.</p> <p>On 05/12/24, a B/P reading of 121/62 mm/Hg was recorded and Midodrine was administered.</p> <p>On 05/14/24, a B/P reading of 128/71 mm/Hg was recorded and Midodrine was administered.</p> <p>On 05/25/24, a B/P reading of 126/70 mm/Hg was recorded and Midodrine was administered.</p> <p>On 06/05/24, a B/P reading of 130/75 mm/Hg was recorded and Midodrine was administered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/16/24, a B/P reading of 119/68 mm/Hg was recorded and Midodrine was held.</p> <p>On 07/13/24, a B/P reading of 153/68 mm/Hg was recorded and Midodrine was administered.</p> <p>On 08/01/24, a B/P reading of 118/65 mm/Hg was recorded and Midodrine was held.</p> <p>On 09/05/24, a B/P reading of 141/76 mm/Hg was recorded and Midodrine was administered.</p> <p>On 09/15/24, a B/P reading of 143/75 mm/Hg was recorded and Midodrine was administered.</p> <p>On 10/25/24, a B/P reading of 148/72 mm/Hg was recorded and Midodrine was administered.</p> <p>On 11/23/24, a B/P reading of 96/55 mm/Hg was recorded and Midodrine 5 mg was held.</p> <p>On 11/30/24, a B/P reading of 136/57 mm/Hg was recorded and Midodrine was administered.</p> <p>On 12/06/24, a B/P reading of 151/73 mm/Hg was recorded and Midodrine was administered.</p> <p>Interview with Regional Clinical Nurse (RCN) #622 on 02/25/25 at 3:40 P.M., verified Resident #05 did not receive Midodrine as ordered on the aforementioned dates.</p> <p>Review of the facility policy titled Long Term Care Facility Pharmacy Services and Procedures Manual dated 04/30/24 stated the facility staff should also refer to the facility policy regarding medication administration and should comply with applicable law and the state operations manual when administering medications.</p> <p>Review of the facility's standing orders titled [NAME] Community Standing Orders dated 11/24, revealed Midodrine parameters were to hold the medication if systolic B/P was above 120 mm/Hg and to be administered if the systolic B/P was below 120 mm/Hg and if consistently held, the physician was to be notified.</p>		

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NAME OF PROVIDER OR SUPPLIER  Trinity Community at Fairborn		STREET ADDRESS, CITY, STATE, ZIP CODE  789 Stoneybrook Trail Fairborn, OH 45324	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure residents' medications were stored properly. This affected one Resident (#26) out of the three residents reviewed. The facility census was 88.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #26 revealed he was admitted to the facility on [DATE]. His diagnoses included, essential primary hypertension, gastro-esophageal reflux disease, diabetes mellitus (DM), obstructive sleep apnea, chronic kidney disease, bradycardia, depression, and obesity.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #26, dated 01/31/25, revealed he was cognitively impaired, and the resident was dependent on staff for medication administration.</p> <p>Observation of Resident #26's room on 02/18/25 at 10:51 A.M. with Licensed Practical Nurse (LPN) #680 and Certified Nursing Assistant (CNA) 598, revealed a half full bottle or over the counter (OTC) bottle Pepto Bismol on the resident's table. LPN #680 verified the bottle of Pepto Bismol and stated the resident was required to have all medications administered by facility staff and was not permitted to have any medications at his bedside.</p> <p>Interview with Resident #26 on 02/18/25 at 2:00 P.M., revealed he had the Pepto Bismol at his bedside because he felt nauseated on 02/17/25.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44080</p> <p>Based on record review, observations, staff interviews, interview with the local Health Department staff, review of facility policies, review of the Center for Disease Control and Prevention (CDC) guidance, and review of Ohio Department of Health's (ODH) guidance for reporting infectious diseases, the facility failed to develop and implement effective infection control procedures which included when and to who potentially communicable diseases should be reported, failed to ensure the local Health Department was notified in a timely manner of a facility gastrointestinal illness (GI) outbreak and failed to track the residents and employees who developed GI related symptoms as part of their infection surveillance plan. This affected 13 Residents (#24, #22 #10, #35, #68, #66, #27, #02, #59, #07, #61, #237, #236, and #11) but had the potential to affect all residents at the facility. The facility census was 88.</p> <p>Findings include:</p> <p>Review of a list of residents with GI related symptoms provided by the Director of Nursing (DON) included the following: Resident #24 on 02/12/25, Resident #22 on 02/06/25, Resident #10 on 02/14/25, Resident #35 on 02/14/25, Resident #68 on 02/15/25, Resident #66 on 02/15/25, Resident #27 on 02/17/25, Resident #2 on 02/17/25, Resident #59 on 02/17/25, Resident #7 on 02/17/25, Resident #61 on 02/17/25, Resident #237 on 02/17/25, Resident #236 on 02/18/25, and Resident #11 on 02/14/25.</p> <p>Review of the staff schedules dated from 02/13/25 through 02/18/25 revealed the following 20 staff members called off related to illnesses: Licensed Practical Nurses (LPNs) #922, #535, and #500. Certified Nursing Assistants (CNAs) #573, #575, #560, #593, #546, #559, #563, #576, #509, #507, #548, #598, #524, #530, #675, and #539.</p> <p>Interview with Infection Control Preventionist (ICP) #549 on 02/18/25 at 2:28 P.M verified Residents #24, #22 #10, #35, #68, #66, #27, #02, #59, #07, #61, #237, #236, and #11 developed GI related symptoms starting on 02/12/25 and they were not recorded on the infection control surveillance log. ICP #549 verified 20 employees called off for illness and she was not tracking the surveillance for the GI symptoms by the employees when they called off sick.</p> <p>Interview with Director of Nursing (DON) on 02/18/25 at 2:30 P.M., verified Residents #24, #22 #10, #35, #68, #66, #27, #02, #59, #07, #61, #237, #236, and #11 developed GI related symptoms starting on 02/12/25 and the residents were not being tracked as part of their infection control surveillance plan. The DON stated they could not keep track of the residents who had symptoms. The DON also verified the aforementioned 20 employees called off for illness and they were not being tracked according to their infection control surveillance plan.</p> <p>Interview with Scheduler #660 on 02/19/25 at 11:25 A.M., revealed employees were supposed to call off every day when they were sick. Scheduler #660 stated a nurse, or manager placed the employee call-offs in the On-Call Shift Application and a description of the call off. Scheduler #660 stated the DON informed her about the employees calling off due to GI related symptoms.</p> <p>Interview with County Health Department Nurse #880 on 02/19/25 at 3:51 P.M., revealed their department had not received any information related to the facility of having a GI virus outbreak.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with Nurse Practitioner (NP) #770 on 02/19/25 at 4:40 P.M. revealed she was first notified on 02/14/25, when Resident #35 developed GI related symptoms. NP #770 stated she was notified again on Monday 02/17/25 of additional Residents #02, #07, #27, #59, and #68 with GI related symptoms. NP #770 stated she started the residents on a nausea, vomiting and diarrhea protocol on Monday 02/17/25. NP #770 stated if a resident had nausea or vomiting, the staff were to place an order for Zofran (antiemetic) four milligrams (mg) every eight hours as needed and if a resident had diarrhea, staff were to place an order for Imodium (anti-diarrhea) to take two initial tablets, and then can take one tablet every hour, and up to six tablets in one 24 hours as needed.</p> <p>Interview with DON on 02/19/25 at 5:20 P.M., verified the facility didn't timely notify the local Health Department of the GI virus outbreak. The DON also noted they were notifying the resident's families of the GI virus outbreak.</p> <p>Review of the CDC guidance titled Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings (2011), revealed as with all outbreaks, notify appropriate local and state health departments, as required by state and local public health regulations, if an outbreak of Norovirus gastroenteritis is suspected. The guidance further stated Personnel who work with, prepare or distribute food must be excluded from duty if they develop symptoms of acute gastroenteritis. Personnel should not return to these activities until a minimum of 48 hours after the resolution of symptoms or longer as required by local health regulations.</p> <p>Review of ODH guidance titled, Know Your ABCs: A Quick Guide to Reportable Infectious Diseases in Ohio, effective 08/01/19 revealed under the section Class C, facilities should report an outbreak, unusual incident or epidemic of other diseases by the end of the next business day.</p> <p>Review of the facility policy titled Infection Surveillance Policy dated 01/13/23 revealed a system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommend infection prevention and control practices in order to reduce infections and prevent the spread of infections. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to facility's Quality Assessment and Performance Improvement (QAPI) Committee, and public health authorities when required. All residents' infection will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. Outbreaks will be investigated. Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on observation, staff interview, record review and review of facility policy, the facility failed to maintain an effective pest control program. This affected Resident (#13) and had the potential to affect all 23 Residents living on the 200 unit. The facility census was 88.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #13 revealed he was admitted to the facility on [DATE]. His diagnoses included anemia, heart failure, hypertension, ortho static hypertension, diabetes mellitus (DM), and aphasia. Resident #13's room was located on the 200-hall.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #13 dated 01/28/25, revealed the resident had impaired cognition.</p> <p>Observation of Resident #13's bed on 02/20/25 at 2:50 P.M. with Certified Nursing Assistant (CNA) #511 revealed the resident's bed had active gnats flying around the bed. Resident #13's bed had food crumbs, and the bed was soiled. Interview at the same time with CNA #511 verified the condition of Resident #13's bed.</p> <p>2) Observation of the dining room on the 200-hallway on 02/18/25 at 12:00 P.M. with Licensed Practical Nurse (LPN) #564, revealed a breakfast tray sitting on the cabinet and two large juice containers in the sink and the cabinet area was soiled with food debris. The sink, faucet and cabinet area had multiple ants crawling around. Interview at the same time with LPN#564, verified the area was soiled with food debris and numerous ants crawling around the sink and cabinet area.</p> <p>Continued observation of dining room on the 200-hallway on 02/18/25 at 1:56 P.M., revealed the ants remained crawling on and around the sink.</p> <p>Observation of the dining room on the 200-hallway on 02/20/25 at 1:16 P.M. with Housekeeper (HK) #623, revealed a large amount of dead and live ants crawling on the sink, on the faucet, and on the cabinet next to the refrigerator. HK #623 stated maintenance was aware of the issue with the active ants.</p> <p>Interview with the Environmental Service Director (ESD) #625 on 02/20/25 02:32 P.M., revealed the facility has a pest control company that will treat the facility monthly. During the interview with ESD #625, he stated he was aware of the active ants, then laughed and exited the conference room without completing the interview.</p> <p>Review of the facility policy titled, Pest Control, dated 10/10, confirmed the facility will maintain an effective pest control program. Further review of the facility policy stated this facility maintained an on-going pest control program to ensure that the building was kept free of insects and rodents.</p>		