STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366100	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Post Acute	1001 Alex Bell Road Centerville, 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and transportation interview, the facility failed to properly discharge a resident. This affected one (Resident #117) out of three reviewed for discharge. The facility census was 111.Findings include:Review of Resident #117's medical record revealed an admission date of 11/18/25 and a discharge date of 04/25/26 with diagnoses of paraplegia, complete, other acute osteomyelitis, right ankle and foot, neuromuscular dysfunction of bladder, and chronic pulmonary embolism. Further review revealed Resident #117's wounds to the bilateral heels were healed. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed resident had moderate cognitive impairment with no behaviors documented. Resident required assistance with eating, required partial assistance with oral hygiene, required substantial assistance with bathing, personal hygiene, and was dependent on staff assistance with toileting hygiene, dressing, bed mobility, transfers, and wheelchair mobility.Review of the Care Plan dated 04/25/26 revealed Resident #117 was at risk for decline in activities of daily living (ADLs) with interventions including the resident required two person assist with all (ADLs) and care due to behaviors and fabrication of false allegations towards staff. Further review of the Care Plan revealed Resident #117 exhibits physical and verbal behaviors towards staff, throwing items, hitting staff and cursing at staff with interventions of medications as needed, encourage resident to verbalize feelings, and psych consult as needed. Review of the nurse's note dated 04/25/26 at 7:30 P.M. revealed Resident #117 became physically aggressive towards staff.Review of the nurse's note dated 04/25/26 at 11:42 P.M. revealed at 7:29 P.M. Resident #117 had physically assaulted a nurse at the facility, threw a soiled brief torn up at the nurse, and spit on the nurse. The police was called. Police arrived, took witness statements, and was going to arrest Resident #117. Upon resident voicing concerns of wounds, the resident requested to go to the emergency room (ER). Further review of Resident #117's progress notes revealed no documented behaviors prior to this incident. Additionally, there was no documentation to support the resident had been offered mental health services. Review of the ER note dated 04/26/26 at 1:35 A.M. revealed the ER nurse called the facility and spoke with Licensed Practical Nurse (LPN) Supervisor #282 and informed her that Resident #117 would not be going to jail and would be returning to the facility.Review of the Run Report from Transportation Company (TC) #500 revealed Resident #117 left the hospital on [DATE] at 1:41 A.M. and returned to the facility. Upon arriving at Centerville Post Acute, nursing staff met transport outside at the door, and refused Resident #117. Centerville Post Acute staff reported they refused Resident #117 because they didn't feel safe and reported they would clock out and go home if Resident #117 came into the facility. At this point, the resident was taken to his previous residence, his mother's home.Further review of the medical record revealed no evidence a discharge notice was given to Resident #117. Interview on 05/19/26 at 3:46 P.M. with the Director of Nursing (DON) confirmed Resident #117 was not given discharge paperwork from LPN Supervisor #282 on 04/25/26. Interview confirmed Resident # 117 was sent out the hospital due to assault on a staff member on 04/25/26 and the facility did not feel the hospital did a thorough psych evaluation, so the facility sent the resident back to the hospital. Interview confirmed Resident #117 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366100	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Post Acute	1001 Alex Bell Road Centerville, 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was a paraplegic. The DON reported the resident had become upset on 04/25/26 because the facility initiated two staff present for care due to behaviors. Telephone call received on 05/20/26 at 11:36 A.M. from LPN Supervisor #282 confirmed she was the nurse on duty 04/26/26 at 1:35 A.M. when the Registered Nurse (RN) from the hospital called reporting Resident #117 was not going to jail and was returning to the facility. Interview also confirmed when Resident #117 returned to the facility on [DATE] around 3:35 A.M. she refused for the resident to readmit. Interview confirmed LPN Supervisor #282 felt the facility did not have the means to care for Resident #117 due to his behaviors. Interview confirmed she felt since Resident #117 assaulted a staff member, he should not be at the facility. Interview confirmed the DON told her not to allow the resident to readmit to the facility and to tell the squad to take him back to the hospital.Interview on 05/20/26 at 2:47 P.M. with the DON confirmed on 04/26/26, Resident #117 was brought back to the facility from the hospital and the facility wanted him sent back to the hospital since they felt the hospital didn't evaluate him for psych. Interview confirmed the facility does not have paperwork where they sent Resident #117 back to the hospital on [DATE]. Interview confirmed Resident #117 was not allowed back in the facility. Interview confirmed the emergency room paperwork dated 04/26/26 listed he was seen for behaviors and wounds. Interview also confirmed the facility did not contact their psych services for a review for Resident #117.Interview on 05/20/26 at 3:23 P.M. with Director of TC #500 confirmed on 04/26/26 when Resident #117 was returned from the hospital, the nurse at Centerville Post Acute said, she would clock out and leave if Resident #117 was brought into the facility. TC #500 staff called the police to have assistance with the situation and resident was taken to his mother's home.This deficiency represents non-compliance investigated under Complaint Number 296858.