STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366400	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beavercreek Health and Rehab	3854 Park Overlooke Drive Beavercreek, OH 45431

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record record review and staff interview the facility failed to document discharge planning for one (Resident #27) of three residents reviewed for discharge planning. The facility census was 69 residents.Findings include: Review of the medical record for Resident #27 revealed an admission date of 09/19/24 with diagnoses including chronic obstructive pulmonary disease, atherosclerotic heart disease, anxiety disorder, hypertension, osteoarthritis, and depression, and a discharge date of 06/11/25. Review of her the care plan for Resident #27 dated 01/08/25 revealed the resident had planned to be at the facility for a short time and wanted assistance in planning steps to be able to return home safely. Review of the Minimum Data Set (MDS) assessment for Resident #27 dated 04/04/25 revealed the resident was cognitively intact and required set-up or supervision with activities of daily living (ADLs.) Review of a 30-day discharge notice for Resident #27 dated 05/12/25 revealed the was being discharged for non-payment of services and would be going to her sister's home. Review of the MDS assessment for Resident #27 dated 06/11/25 revealed the resident was discharged to the community and was not anticipated to return to the facility. Review of the physician's orders for Resident #27 revealed an order dated 06/10/25 for the resident to discharge to home with hospice care. Review of the progress notes for Resident #27 dated 06/11/25 to 08/27/25 revealed there was no documentation regarding the resident's discharge from the facility. Review of the recapitulation of stay form for Resident #27 dated 06/11/25 revealed the resident was independent with mobility and activities of daily living and had participated in self-directed and occasional group activities. All other sections of the form were blank. Interview on 08/27/15 at 11:20 A.M. with Assistant Director of Nursing (ADON) #109 verified there should have been a nursing discharge note for Resident #27 and the recapitulation of stay form should have been fully completed. He stated he was not aware of the details of her discharge planning as that would be the responsibility of the social worker. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/27/25 at 11:50 A.M. with the Administrator confirmed Resident #27 had been given a 30-day discharge notice due to non-payment and had gone home with her sister, and he was not sure what discharge planning had taken place. The Administrator verified the staff should have completed a nursing note and the recapitulation of stay document upon discharge for Resident #27. Interview on 09/02/25 at 2:25 P.M. with the former Social Worker (SW) #121 confirmed she was not present when Resident #27 was discharged . SW #121 reported Resident #27's insurance gave notice they would not cover a long-term stay. Resident #27 was planning to try to go to her sister's house and she had recommended home health care and therapy but was not sure what had been set up when Resident #27 actually discharged as the SW was no longer working at the facility. This deficiency represents noncompliance investigated under Complaint Number OH00165679 (iQIES 1344432.)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and online information on pressure ulcers from Medscape the facility failed to timely treat pressure wounds. This affected one (Resident #10) of three residents reviewed for pressure ulcers. The facility census was 69 residents. Findings include:Review of the medical record for Resident #10 revealed admission date of 07/18/25 with diagnoses including stage four pressure ulcer, stroke, liver cirrhosis, and depression and a discharge date of 07/22/25.Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 07/22/25 revealed the resident had severely impaired cognition and was dependent upon staff for activities of daily living (ADLs.)Review of the admission assessment for Resident #10 dated 07/18/25 revealed the resident had a left heel pressure ulcer which measured two centimeters (cm) in length by two in width with the depth not measured and the resident had a left outer ankle pressure ulcer which measured two cm in length by two cm in width with the depth not measured. Review of the physician's orders for Resident #10 revealed orders dated 07/21/25 to cleanse the left heel pressure ulcer and left outer ankle pressure ulcer with normal saline and apply skin prep every shiftInterview on 08/26/25 at 11:02 A.M. with Assistant Director of Nursing (ADON) #109 confirmed Resident #10 was admitted on [DATE] with deep tissue injuries (DTIs) to her left heel and left outer ankle. ADON #109 confirmed the treatment for the pressure ulcers was not initiated until 07/21/25.Review of online resource Medscape at https://emedicine.medscape.com/article/190115-treatment revealed once a pressure ulcer has developed immediate treatment is required.This deficiency represents noncompliance investigated under Complaint Number 2582540 and Complaint Number 2572464.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of recorded video footage, staff interview, and review of the facility policy, the facility failed to ensure staff timely reported falls, failed to assess residents for injuries following falls, and failed to investigate falls. This affected one (Resident #17) of three residents reviewed for falls. Based on medical record review, observation, and staff interview, the facility failed to ensure fall prevention interventions were implemented per the resident care plan. This affected one (Resident #12) of three residents reviewed for falls. The facility census was 69 residents.Findings include:1.Review of the medical record for Resident #17 revealed admission date of [DATE] with diagnoses including chronic obstructive pulmonary disease, dementia, depression, anxiety and psychotic disorder with delusions. The resident expired on [DATE].Review of the care plan for Resident #17 initiated on [DATE] revealed the resident was at risk for falls related to multiple comorbidities including weakness, chronic pain, impaired balance, unsteady gait and behaviors. Interventions included to encourage the resident to ask for assistance, ensure resident is wearing appropriate footwear, and keep environment well-lit and free of clutter.Review of the Minimum Data Set (MDS) assessment for Resident #17 dated [DATE] revealed the resident was cognitively impaired and was dependent on staff for assistance with activities of daily living (ADLs.)Review of a video recording undated of Resident #17 revealed a female resident was on the floor opposite the wall, beside her bed which was in low position. A second person bent down and grabbed the resident under her arms and attempted to put the resident back on the bed. Resident #17 kept her left leg straight and did not assist in the transfer. The resident was wearing socks which allowed her feet to slide hindering the transfer. The video showed two attempts of the person to hoist the resident onto the bed without success before ending.Interview on [DATE] at 12:09 P.M. with the Administrator confirmed he was aware of the video of Resident #17's fall and had been informed of the fall by the resident's family member on [DATE]. The Administrator confirmed the aide in the video was Certified Nursing Assistant (CNA) #114. The Administrator stated when he was made aware of the video CNA #114 was suspended pending an investigation on [DATE], and the facility had disciplined the aide and provided education on the fall policy. The Administrator was unsure if CNA #114 had provided a statement regarding the fall circumstances and did not provide a statement by the end of the survey.Review of the facility fall investigation dated [DATE] revealed it included a suspension notice for CNA #114 due to picking a resident up after finding her on the floor during rounding and not reporting to the nurse. The investigation form indicated the facility was unable to investigate the fall due to the timing of the incident reporting. The investigation did not include a statement from CNA#114 regarding the circumstances of the fall.Review of the facility policy titled Falls-Clinical Protocol dated 2001 revealed staff would evaluate and document falls that occurred and the nurse would assess and document vital signs, injury, precipitating factors, and details of how the fall occurred.2.Review of the medical record for Resident #12 revealed admission date of [DATE] with diagnoses including hemiparesis and hemiplegia left dominant side following stroke, COPD, and depression.Review of the care plan for Resident #12 dated [DATE] revealed the resident was at risk for falls due to left sided hemiplegia, weakness tremors and impaired balance. Interventions included to keep the call light within reach, keep the bed in low position, and to place a fall mat to bilateral sides of the bed.Observation on [DATE] at 3:16 P.M. revealed Resident #12 was in bed, and the bed was in the highest position with no floor mat in place to the right side of the bed. Interview and observation on [DATE] at 3:19 P.M. with CNA #101 verified Resident #12's bed was too high and she lowered the bed. CNA #101 stated she was unsure if Resident #12 should have a mat on both sides of the bed and added he probably should because he could roll out on either side. CNA #101 confirmed Resident #12 did not have a fall mat on the floor to the right side of the bed, and there was only one mat present in the room.This deficiency represents noncompliance investigated under Complaint Number 2594984 and Complaint 2582540 and Complaint Number 2572464 and Complaint Number OH00165679 (1344432.)