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	12/30/2025

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 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 observation, interview, record review, and policy review, the facility failed to assess and implement new interventions after an unstageable pressure ulcer was found on Resident #16's left foot. This affected one (Resident #16) of three residents reviewed for pressure wounds. The facility census was 62. Medical record review for Resident #16 revealed an admission date of 07/17/25 with diagnoses including quadriplegia and polyneuropathy. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #16 was cognitively intact. Her functional status was dependent for bathing, dressing, and positioning. Review of the care plan for Resident #16 revealed the resident is at risk for pressure ulcers. Interventions included weekly skin checks, floating heels, turning and repositioning, pressure reducing mattress, and wheelchair cushion. Review of the nursing notes dated 12/21/25 revealed that while Resident #16 was being provided a bed bath, a wound measuring 2.9 x 2 x.2 was found on the the ball of Resident #16's left foot. Review of the triage notes dated 12/21/25 revealed the facility was instructed to keep a pillow under Resident #16's foot to relieve pressure and contact the primary care provider on Monday for an evaluation. Review of the Interdisciplinary Team note date 12/22/25 revealed that Resident #16 believes her wheelchair's left foot rest caused the wound. Resident #16 has no feeling in her legs and couldn't tell it was rubbing while up in wheelchair. Therapy will evaluate Resident #16 in the wheelchair and adjust the left footrest to not rub against her foot. Observation on 12/22/25 at 2:00 P.M. revealed Resident #16 was in her wheelchair without a pillow placed under her foot. Interview on 12/22/25 at 2:57 P.M. with Resident #16 verified the facility had not started any new interventions to alleviate pressure from her left foot. Review of the Wound Evaluation and Management Summary notes dated 12/23/25 revealed the wound on Resident #16's left foot was unstageable and measured 3 x 3 x 0.1 cm. Interview on 12/23/25 at 10:36 A.M. with Licensed Practical Nurse (LPN) #446 revealed she believed the bolsters on Resident #16's bed caused the pressure ulcer due to how the resident prefers to be positioned. Interview on 12/23/25 at 10:09 A.M. with Director of Nursing (DON) #423 verified they did not evaluate Resident #16 after the pressure ulcer was found. DON #423 verified that they were not sure if the bolsters on the bed or the wheelchair foot pedals caused the pressure injury. DON #423 verified that Resident #16 has not been evaluated by therapy and there have not been any new interventions added. Review of the facility policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, with a revision date of March 2014, revealed nursing staff and attending physician will asses and document a resident's significant risk factors for developing pressure sores.

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
	366400	A. Building B. Wing	12/30/2025

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 0689 Level of Harm - 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)

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	12/30/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of hospital records, staff interviews, and review of facility policy, the facility failed to ensure a safe transfer via a mechanical Hoyer lift. This resulted in Actual Harm on 12/16/25, when one staff member transferred Resident #63 via Hoyer lift and the Hoyer pad broke causing the resident to fall, which resulted in fractures of her bilateral femurs and a Lumber #1 (L1) fracture to her spine, requiring admission to the hospital for surgical repair to her bilateral femurs. This affected one (Resident #63) of three residents reviewed for accidents. The facility census was 62.Findings include:Review of the medical record for Resident #63 revealed an admission date of 02/27/24 with diagnoses of cerebral palsy, type II diabetes mellitus with diabetic polyneuropathy, morbid (severe) obesity due to excess calories, and hypertensive heart disease with heart failure. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #63 was dependent on staff assistance with toileting hygiene, bathing, dressing, and transfers. Review of the nurse's note dated 12/16/25 at 6:27 P.M. revealed Resident #63 fell from a Hoyer lift due to the Hoyer pad strap breaking. The resident was sent to the emergency room due to complaints of pain. Review of the Interdisciplinary Team (IDT) note dated 12/17/25 at 9:36 A.M. documented Resident #63 was being transferred with a Hoyer lift by two Certified Nursing Assistants (CNAs) #470 and #490 and fell from the Hoyer when the Hoyer strap broke. Review of the hospital documentation dated 12/21/25 revealed Resident #63 admitted from a different hospital after a fall from a Hoyer Lift on 12/16/25 resulting in bilateral femur fractures and L1 compression fracture. On 12/17/25, the resident had surgical procedures to the right distal femur and closed treatment to the left nondisplaced distal femur fracture. X-rays ordered for a sitting up lumbar region for the L1 compression fracture. Interview on 12/21/25 at 11:40 A.M. with Licensed Practical Nurse (LPN) #444 confirmed the Hoyer pads were falling apart prior to Resident #63's fall last week. LPN #444 stated staff had reported their concerns for months to administration, but nothing was done until the fall, then all of a sudden, they got rid of the bad ones and the facility had good ones now. Interview on 12/21/25 at 11:49 A.M. with LPN #416 confirmed the Hoyer pads were falling apart, and multiple staff had reported it to administration, then Resident #63 fell. Since then, staff removed all the bad ones, and the facility has had nice ones now. Staff had been reporting this concern for months, and nothing was done until the fall. Interview on 12/21/25 at 11:31 A.M. with CNA #440 confirmed she had reported to the administration on multiple occasions that the Hoyer pads were not in good repair and needed replaced prior to the 12/16/25 when Resident #63 fell. Interview on 12/21/25 at 11:22 A.M. with CNA #470 confirmed on 12/16/25, Resident #63 fell from the Hoyer lift during a transfer. Interview confirmed she had checked the Hoyer pad prior to using it and didn't see any problems with it. Interview also confirmed when she lifted the Hoyer, the pad broke at one of the handles, and Resident #63 fell to the floor. Interview confirmed CNA #490 was in the room on the other side of the curtain washing her hands when the incident occurred. CNA #470 verified staff were to use two persons at all times with Hoyer transfers. Interview on 12/21/25 at 12:56 P.M. with CNA #491 confirmed the Hoyer pads were in poor condition prior to Resident #63's fall from the Hoyer. Interview confirmed she told the management team multiple times about how bad the Hoyer pads were in a group chat and they didn't do anything about it. Interview on 12/21/25 at 3:03 P.M. with the Director of Nursing (DON) confirmed the facility did not have a plan in place to inspect the Hoyer pads on a routine basis prior to the fall on 12/16/25, where Resident #63 fell from the Hoyer when the Hoyer pad broke. Interview confirmed Resident #63 sustained bilateral femur fractures requiring surgical repair, and an L1 compression fracture. Interview confirmed Resident #63 was still in the hospital at this time. Interview also confirmed the facility did a sweep of all the Hoyer pads in the facility to ensure they were all in good condition and if they weren't in good condition they were thrown away. The DON was unable to give a number of Hoyer pads that were discarded due to not being in good condition. Interview on 12/22/25 at 8:59 A.M. with CNA #490 confirmed on 12/16/25 she was called into Resident #63's room to help with a transfer. Upon entering the room, she stopped on the other side of the curtain, to wash her hands and put on gloves. Before she could get her gloves on, CNA #470 lifted Resident #63 with the Hoyer, the Hoyer pad broke and Resident #63 fell from the Hoyer onto the floor. Interview confirmed she did not see CNA #470 lift Resident #63 in the Hoyer, and she did not see Resident #63 fall out of the Hoyer, she just heard it happen. Interview confirmed staff are to use two persons at all times with Hoyer transfers. Interview on 12/22/25 at 3:17 P.M. with CNA #490 confirmed she, along with other CNAs, had reported the Hoyer pads needing replaced and

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	12/30/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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	12/30/2025

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 0755 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 record review, staff interviews, and policy review, the facility failed to administer medications per physician orders. This affected two (Residents #05 and #08) of three residents reviewed for medication administration. The facility census was 62.Findings include:1.Review of the medical record for Resident #05 revealed an admission date of 03/21/25 with diagnoses of type II diabetes mellitus with foot ulcer, non-pressure chronic ulcer of other part of left foot with fat layer exposed, chronic combined systolic (congestive) and diastolic (congestive) heart failure.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of the physician orders revealed the following:-An order dated 03/22/25 for Repatha Subcutaneous Solution Prefilled Syringe (Evolocumab). Inject 140 mg/ml subcutaneously one time a day every 21 day(s) for hyperlipidemia every 3 weeks with a discontinue date of 05/24/25.-An order dated 05/24/25 for Repatha Subcutaneous Solution Prefilled Syringe (Evolocumab). Inject 140 mg/ml subcutaneously one time a day every 21 day(s) for hyperlipidemia every 3 weeks with a discontinue date of 09/08/25.-An order dated 09/10/25 for Repatha Subcutaneous Solution Prefilled Syringe (Evolocumab). Inject 140 mg/ml subcutaneously one time a day every 21 day(s) for hyperlipidemia every 3 weeks with a discontinue date of 12/05/25.-An order dated 12/05/25 for Repatha Subcutaneous Solution Prefilled Syringe (Evolocumab). Inject 140 mg/ml subcutaneously one time a day every 21 day(s) for hyperlipidemia every 3 weeks.Review of the Medication Administration Records (MAR) revealed on 04/12/25, 05/03/25, 06/16/25, 07/28/25, and 08/18/25 the Repatha was administered. Further review of the MARs revealed on 05/24/25, 07/07/25, 09/12/25, 10/08/25, 11/03/25, 11/14/25, and 11/21/25 the Repatha was not administered and was signed as 'see nurses notes.'Review of the Pharmacy Packing Slip Proof of Deliver forms for Resident #05 revealed Repatha 140 mg/ml quantity of one was delivered on 03/22/25, 04/12/25, 05/05/25, 05/24/25, 07/07/25, 07/28/25, 09/12/25, and 12/11/25.Interview on 12/23/25 at 2:46 P.M. with the Director of Nursing (DON) confirmed Resident #05 did not receive their Repatha as ordered every three weeks starting on 03/22/25. Interview also confirmed the physician orders were routinely, but the pharmacy was not delivering the medication per orders. Interview confirmed when the facility noted it was not available, they would sometimes discontinue the orders and write a new order so the resident would get it delivered. Interview confirmed the medication has a short shelf life so the pharmacy would not deliver it early. Interview also confirmed that the resident received only five of the thirteen doses of Repatha between 03/22/25 and 11/29/25. Interview also confirmed that only eight doses show as delivered.2. Review of the medical record for Resident #08 revealed an admission date of 12/30/24 with diagnoses of respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia, type II diabetes mellitus with diabetic polyneuropathy, major depressive disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and chronic diastolic (congestive) heart failure.Review of the Quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of the physician orders revealed the following:-An order dated 06/30/25 for Repatha Subcutaneous Solution Prefilled Syringe 140 mg/ml (Evolocumab). Inject 140 mg subcutaneously one time a day every 2 weeks on Monday for hypertriglyceridemia with a discontinue date of 12/01/25.-An order dated 12/02/25 for Repatha Subcutaneous Solution Prefilled Syringe 140 mg/ml (Evolocumab). Inject 140 mg subcutaneously one time a day every 2 weeks on Wednesday for hypertriglyceridemia.Review of the MAR revealed the Repatha was not administered in June 2025. Further review of the MARs revealed the Repatha was administered on 07/28/25, 08/11/25, 08/25/25, and 09/08/25. Further review revealed on 09/22/25, 10/06/25, 10/20/25, 11/03/25, 11/17/25, 12/01/25, and 12/17/25 the Repatha was not administered and signed as, 'see nurses notes.'Review of the Pharmacy Packing Slip Proof of Deliver forms for Resident #05 revealed Repatha Injection 140 mg/ml quantity of one was delivered on 06/28/25, 08/12/25, 08/25/25, 09/22/25, and 12/01/25.Interview on 12/23/25 at 2:46 P.M. with the DON confirmed Resident #08 did not receive their Repatha as ordered every two weeks starting on 06/26/25. Interview also confirmed the physician orders were routinely, but the pharmacy was not delivering the medication per orders. Interview confirmed when the facility noted it was not available, they would sometimes discontinue the orders and write a new order so the resident would get it delivered. Interview confirmed the medication has a short shelf life so the pharmacy would not deliver it early. Interview also confirmed that the resident received only four of the eleven doses of Repatha between 06/26/25 and 12/17/25. Interview also confirmed that only five doses show as delivered