STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365005	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edith Lane of Cincinnati	2586 Lafeuille Avenue Cincinnati, OH 45211

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to provide a sanitary, clean, and safe environment, This had the potential to affect all 12 Residents (#01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, and #12) who resided on the Secured Women's Behavioral Unit and 34 Residents (#44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76 and #77) who resided on the One [NAME] Unit and utilized the main entrance. The facility census was 145.1) Review of the medical record for Resident #12 revealed an admission date of 02/09/24. Diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), essential primary hypertension, hypothyroidism, schizoaffective disorder, osteoarthritis, and osteoarthritis.Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 12/30/25, revealed she had impaired cognition, required supervision or moderate assistance from staff for activities of daily living (ADL). She was dependent on staff for medication administration.Observation on 03/18/26 at 11:18 A.M. with Certified Nurse Aide (CNA) #182, revealed Resident #12's bathroom was soiled with brown splatter up the corner of the wall behind the toilet. The toilet was heavily soiled, the floor was blackened with dirt and debris, brown splatter was observed on the opposite wall of the toilet. Resident #12's bedroom wall was soiled and scuffed up with exposed dry wall. Resident #12's wall around the receptacle and under the light was soiled with an unknown splatter and dried substance on the wall. Interview with CNA #182 at the same time verified the findings in Resident #12's room. 2) Review of the medical record for Resident #07 revealed an admission date of 03/07/23. Diagnoses included essential primary hypertension, anti-social personality disorder, inhalant abuse, diabetes mellitus (DM), schizoaffective disorder, bipolar disorder, dementia, and anxiety disorder.Review of the MDS assessment for Resident #07 revealed she had severely impaired cognition, required set up assistance or supervision with ADL. She was dependent on staff for medication administration.Observation on 03/18/26 at 11:21 A.M. with CNA #182, revealed Resident #07 did not have sheets on her bed. Resident #07's bed had a wadded-up blanket heavily soiled with yellow and brown substance. A swarm of fruit flies were on the wadded up heavily stained blanket and all over the bed. The floor in front of Resident #07's bed was blackened with dirt and debris. Resident #07's bedroom had a soiled incontinent brief with drops of what appeared to be blood and stool all around the soiled brief. The floor was stained with reddish brown droplets. The wall had brown, dried splatter all over it by the toilet and the bathroom floor was missing tiles.During an interview on 03/18/26 at 11:21 A.M., CNA #182 stated the wadded-up blanket on Resident #07's bed was soiled with urine. CNA #182 verified the conditions of Resident #107's room. During an interview on 03/18/26 at 11:23 A.M., Housekeeper (HK) #168 walked into Resident #07's bathroom and confirmed the stool and blood on the floor in Resident #07's bathroom. HK #168 stated she does not clean up blood.Observation on 03/18/26 at 2:14 P.M., with CNA #182, revealed Resident #07's bathroom sink had brown water and cigarette butts floating in it. The cold and hot water did not work. The bathroom floor was spotted with a red and brown substance. Interview at the same time with CNA #182 verified the condition of (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #07's room. CNA #182 verified the bathroom had dried blood on the floor. During an interview on 03/18/26 at 2:55 P.M., Maintenance Supervisor (MS) #155 stated he was aware Resident #07 did not have any running water in the bathroom sink and verified the resident's bathroom sink had standing brown water. MS #155 stated the facility had not provided any type of pest treatment to Resident #07's room. MS #155 verified the five ceiling lights were not working in the Women's behavioral dining/activity room. MS #155 stated he was aware of the hole in the wall below the half broke window between the nurse's station and the dining/activity room. MS #155 stated he was not aware of the broken window between the nurse's station and dining/activity room.3) Observation of the women's secured unit on 03/18/26 at 11:25 A.M. with CNA #182, revealed the shower room floor was blackened with dirt and heavily soiled. The shower room had an unknown brown spotted and splatter in the corners of the shower and up the walls. The toilet in the shower room was heavily soiled, and the shower room drain broke off on one side. The ceiling fan was hanging down out of the ceiling and the ceiling was spotted with an unknown black substance. During an interview on 03/18/26 at 11:26 A.M., CNA #182 stated the shower room was utilized by all twelve residents in the women's behavioral unit and verified the conditions of the shower room. CNA #182 stated the unknown substance appeared to be mold. CNA #182 confirmed the ceiling fan was hanging out of the ceiling and the drain was broken with half of the circle drain missing.Observation of the Women's Behavioral Unit on 03/18/26 at 2:10 P.M. with CNA #320, revealed the large dining/activity room had a half-broken window that opened into the nurses station from the dining room. The window was broken in half with a sharp edge on it and underneath the window was a large hole in the wall with exposed dry wall. The dining room/activity room had five large ceiling lights with no light bulbs.During an interview on 03/18/26 at 2:10 P.M., During an interview with CNA #320 at the same time, verified the findings inside the unit. 4) Review of the medical record for Resident #08 revealed an admission date of 09/23/25. Diagnoses included DM, essential primary hypertension, asthma, atherosclerotic heart disease, schizoaffective disorder, anxiety disorder, and gastroesophageal reflux disease (GERD).Review of the MDS assessment for Resident #08 dated 01/23/26, revealed Resident #08 had impaired cognition. Resident #08 required supervision, moderate assistance and set-up assistance for ADL. Resident #08 was dependent on staff for medication administration.During an interview on 03/18/26 at 2:15 P.M., Resident #08 stated she was tired of her room being cold. Resident #08 pointed to her heating unit in her room which had a blanket on it, and a blanket at the base of the window over top of the unit. Resident #08 stated the unit was blowing out cold air and it was very cold in her room. Resident #08 stated the maintenance director told her he fixed the heat, but it continued to blow cold air. Observation of Resident #08's room at the same time, revealed a blanket was on top of the heating unit. The unit was running but cold air filled the room. Resident #08's bathroom was soiled, missing floor tiles, and the toilet was heavily soiled with a black ring around the toilet.During an interview on 03/18/26 at 2:17 P.M., CNA #182 stated Resident #08's room had been blowing cold air for some time; however, she could not say how long. CNA #182 confirmed the bathroom was soiled, missing floor tiles, and had a black ring around the base of the toilet. CNA #182 confirmed the room was very cold.During an interview on 03/18/26 at 2:55 P.M., MS #155 confirmed Resident #08's room heater was blowing cold air. MS #155 stated he was not aware of this because he thought he had repaired the heating unit. MS #155 confirmed Resident #08 had holes in the wall beside her bed and shredded pieces of her privacy curtain hanging from the ceiling.5) Review of the medical record for Resident #04 revealed an admission date of 05/02/23. Diagnoses included essential primary hypertension, DM, atherosclerotic heart disease, schizoaffective disorder, anxiety disorder, and cystitis.Review of the MDS for Resident #04 dated 12/25/25, revealed she had impaired cognition. Resident #04 required set up assistant, supervision or moderate assistance for ADL.Observation on 03/18/26 at 2:16 P.M. revealed Resident #04 had a dish with water under her sink. A large pile of what appeared to be mouse droppings was identified under the sink. The sink did not drain correctly when water was running. During an interview on 03/18/26 at 2:16 P.M., Resident (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#04 stated the small dish of water was for the mice in her room. Resident #04 pointed at the large hole in the corner of her room under the sink and stated the mice lives in the hole and she made it her pet.During an interview on 03/18/26 at 2:55 P.M., MS #155 stated he was aware of the mice droppings under Resident #04's bathroom sink. MS #155 stated he was aware of the mice issue in Resident #04's room and had the facility treated for mice.Review of the most recent facility's Work Orders from the contracted pest control company revealed no specific treatments to Resident #07's room for fruit flies or Resident #04's room for mice.6) Observation of the main entrance to the facility on [DATE] at 2:35 P.M., with CNA #194, revealed a double set of doors with a small concreate pad and awning overhead where residents/visitors and staff entered the building. Resident #62 was observed smoking on the concrete pad and directly outside of the front doors which was a non-smoking area. There were numerous discarded cigarette butts scattered across the ground near the front door, throughout the landscaping rocks on both sides of the doors and all around the trash can with a plastic liner. There was no container for discarded cigarettes. Interview with CNA #194 at the same time verified Resident #62 was smoking directly outside the main entrance door which was a non-smoking area. CNA #194 identified an area across the parking lot which was the designated smoking area. CNA #194 also verified the numerous discarded cigarette butts were scattered on the ground near the front door.During an interview on 03/18/26 at 2:36 P.M., Resident #62 stated he smoked by the main entrance doors often. Subsequent observation of the main entrance to the facility on [DATE] at 11:48 P.M., revealed Residents #46 #56 were observed smoking directly outside the main entrance door in the non-smoking area. The area was still littered with numerous discarded cigarette butts throughout the ground and in the landscaping. During an interview on 03/19/26 at 11:48 P.M., Licensed Practical Nurse (LPN) #388, verified Residents #46 and #56 were smoking directly outside the main entrance in a non-smoking area. LPN #388 verified the large amount of discarded cigarette butts scattered on the ground, throughout the landscaping rocks against the building, and around the trash can with a plastic liner. LPN #388 indicated the designated smoking area was across the parking lot.Review of the facility policy titled, Maintenance Service, dated December 2009, revealed maintenance shall be provided to all areas of the building. The maintenance department was responsible for maintaining the buildings, the grounds, and equipment in a safe and operable manner at all times. The maintenance department would maintain heating/cooling system, plumbing fixtures, and ensure lights are in good working condition. The maintenance director is responsible for inspection of the building. This deficiency represents non-compliance investigated under Master Complaint Number 2797716.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident interview, staff interview, and policy review, the facility failed to maintain a safe smoking environment. This had the potential to affect all 12 Residents (#01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, and #12) who resided on the Secured Women's Behavioral Unit and 34 Residents (#44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76 and #77) who resided on the One [NAME] Unit and utilized the main entrance. The facility census was 145. 1) Observation of the Secured Women's Behavioral Unit on 03/18/26 at 2:08 P.M. with Certified Nurse Aide (CNA) #182, revealed the door exiting to the smoking area contained numerous discarded cigarette butts lying all over the ground and near the door. The sidewalk leading away from the building contained numerous discarded cigarette butts. During an interview on 03/18/26 at 2:10 P.M., CNA #182 verified the door smoking area contained numerous discarded cigarette butts lying on the ground. 2) Review of the medical record for Resident #62 revealed an admission date of 04/04/14. Diagnoses included essential primary hypertension, antisocial personality, inhalant abuse, allergic rhinitis, schizoaffective disorder, bipolar disorder, anxiety disorder, and psychosis.Review of the most recent Smoking Evaluation for Resident #62 dated 04/11/25, revealed the resident was assessed to be an independent smoker with no history of safety concerns regarding smoking.Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #62 was cognitively intact. Review of the medical record for Resident #46 revealed an admission date of 12/09/23. Diagnoses included paranoid schizophrenia, bipolar disorder, essential primary hypertension, anxiety disorder, and psychotic disorder with delusions.Review of the most recent Smoking Evaluation for Resident #46 dated 06/10/24, revealed the resident was assessed to be an independent smoker.Review of the MDS assessment dated [DATE], revealed Resident #46 was cognitively intact. Review of the medical record for Resident #56 revealed an admission date of 12/17/25. Diagnoses included cerebrovascular disease, hemiplegia and hemiparesis, hyperlipidemia, depression, anxiety disorder, and epilepsy. Review of the most recent Smoking Evaluation for Resident #56 dated 05/30/24, revealed Resident #56 was assessed to be an unsafe smoker. Resident #56 had paralysis on the left side of his body and required supervision by staff while smoking.Review of the MDS assessment for Resident #56 dated 02/27/26, revealed the resident was cognitively intact. Observation of the main entrance to the facility on [DATE] at 2:35 P.M., with CNA #194, revealed a double set of doors with a small concreate pad and awning overhead where residents/visitors and staff entered the building. Resident #62 was observed smoking on the concrete pad and directly outside of the front doors which was a non-smoking area. There were numerous discarded cigarette butts scattered across the ground near the front door, throughout the landscaping rocks on both sides of the doors and all around the trash can with a plastic liner. There was no container for discarded cigarettes. Interview with CNA #194 at the same time verified Resident #62 was smoking directly outside the main entrance door which was a non-smoking area. CNA #194 identified an area across the parking lot which was the designated smoking area. CNA #194 also verified the numerous discarded cigarette butts were scattered on the ground near the front door.During an interview on 03/18/26 at 2:36 P.M., Resident #62 stated he smoked by the main entrance doors often. Subsequent observation of the main entrance to the facility on [DATE] at 11:48 P.M., revealed Residents #46 #56 were observed smoking directly outside the main entrance door in the non-smoking area. The area was still littered with numerous discarded cigarette butts throughout the ground and in the landscaping. During an interview on 03/19/26 at 11:48 P.M., Licensed Practical Nurse (LPN) #388, verified Residents #46 and #56 were smoking directly outside the main entrance in a non-smoking area. LPN #388 verified the large amount of discarded cigarette butts scattered on the ground, throughout the landscaping rocks against the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	building, and around the trash can with a plastic liner. LPN #388 indicated the designated smoking area was across the parking lot. During an interview on 03/19/26 at 12:10 P.M., the Administrator stated the facility performed smoking evaluations on the residents with admission and if a resident was to move from a secured unit to an independent unit, or if they had a significant change in health status. Review of the policy titled, Smoking Policy-Residents, dated October 2023, confirmed the facility has established and maintains safe smoking practices. Smoking is only permitted in the designated smoking areas. The policy stated that ashtrays are only emptied in designated receptacles. A resident's smoking status is evaluated upon admission.Review of the facility policy titled, Maintenance Service, dated December 2009, revealed maintenance shall be provided to all areas of the building. The maintenance department was responsible for maintaining the buildings, the grounds, and equipment in a safe and operable manner at all times. The maintenance department would maintain heating/cooling system, plumbing fixtures, and ensure lights are in good working condition. The maintenance director is responsible for inspection of the building.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and staff interviews, the facility failed to ensure the facility had properly operating phones system in place. This had the potential to affect all residents who resided in the facility. The facility census was 145.Observation of Secured Women's Behavioral Unit on 03/18/26 at 11:24 A.M. with Certified Nursing Assistant (CNA) #182, revealed the phone at the nurses station did not work. Observation of a second phone within the unit revealed it was unplugged and not operational. During an interview on 03/18/26 at 11:24 A.M., CNA #182 verified the Secured Women's Behavioral Unit did not have a working phone. CNA #182 stated if a resident's family member tried calling in, there was no way to reach the staff.Observation of Secured Men's Behavioral Unit on 03/18/26 at 11:31 A.M., with CNA # 319, revealed the phone was not plugged in. Interview at the same time with CNA #319, verified the phone was not operational CNA #319 stated the facility had a lot of issues with the phones working and the phones were often not working. During an interview on 03/18/26 at 11:38 A.M., Registered Nurse (RN) #221 assigned to the Secured Men's Behavioral Unit verified the phone was not operational. During an interview on 03/19/26 at 12:46 P.M., Receptionist #325 stated she works Monday through Friday from 9:00 A.M. to 5:00 P.M. Receptionist #325 stated during her off times, the incoming phone calls would roll to the nurse's station depending on what prompt is pushed. Receptionist #325 stated there were times when the phones were not working recently. During an interview on 03/19/26 at 12:55 P.M., the Administrator stated he did not think it was an issue when the families were not able to call into the facility. The Administrator stated the staff would often give families their personal phone numbers. The Administrator stated there was no specific policy regarding phones.