

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Harrison Pavilion Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2171 Harrison 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.			
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure medications were stored appropriately and failed to discard expired medications. This had the potential to affect 35 facility-identified residents who receive medications from medication cart number two/back east, from medication cart short front, and from medication cart short back hall. The facility also failed to discard expired medications and supplies stored in the medication room. This had the potential to affect all of the residents residing in the facility. The facility census was 79 residents. Findings include: Observation on 09/10/25 at 9:33 A.M. of the medication room with Licensed Practical Nurse (LPN) #340 revealed there were two bottles of multi-vitamin with iron with an expiration date of August 2025. The medication room also contained a negative pressure wound therapy foam kit with an expiration date of February 2020 and expired bottles of Vital 1.5 tube feeding (10 bottles expired May 2025 and 41 bottles expired August 2025.) Interview on 09/10/25 at 9:35 A.M. with LPN #340 confirmed the expired items in the medication room were house stock items which should have been discarded. Observation on 09/10/25 at 10:15 A.M. of medication cart number two, back east for resident rooms 17 through 30 with LPN #340 and LPN #310 revealed the top drawer had 11 loose unidentified pills on the bottom of the drawer. The second drawer had 11 tablets found on the bottom of the drawer out of packaging. The third drawer on the right side of the cart had a brown sticky substance with paper stuck to it on the bottom of the drawer. Interview on 09/10/25 at 10:18 A.M. with LPN #340 confirmed the loose unidentified pills in the medication cart number two should have been discarded and the sticky brown substance in the third drawer should have been cleaned. Observation on 09/10/25 at 10:32 A.M. of the medication cart short front for resident rooms 33 through 44 with LPN #340 and LPN #316 revealed the third and fourth drawer on the right had a sticky pink substance on the bottom with paper stuck to it. In the bottom right drawer, there were three bottles of hydrogen peroxide with an expiration date of January 2025 and an intravenous (IV) start kit with chloraprep with an expiration date of 03/31/25. The bottom drawer of the cart had a light brown substance with particles in the bottom below the medications. Interview on 09/10/25 at 10:36 A.M. with LPN #340 confirmed the nurses were to clean the carts daily and as needed, and the expired items should have been discarded. Observation on 09/10/25 at 11:05 A.M. of the medication cart for the short back hall for resident rooms 62, 64, 66, 68 and 70 with LPN #490 revealed the top drawer had 61 loose unidentified pills on the bottom of the drawer. There was a sticky clear substance on the bottom of the drawer with one pill stuck in the substance. The third drawer on the right side of the cart had a pink and brown sticky substance covering the entire bottom. Interview on 09/10/25 at 11:10 A.M. with LPN #490 confirmed the loose pills in the cart should have been discarded and the sticky substances in the cart should have been cleaned. Review of the facility policy titled Storage of Medications dated 2019 revealed the nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Discontinued, outdated, or deteriorated drugs or biologicals are to be returned to the dispensing pharmacy or destroyed.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure food items were stored properly and the kitchen was maintained in clean, sanitary manner. This had the potential to affect all the residents receiving food from the facility. The facility census was 79 residents. Findings include: Observation on 09/08/25 at 10:22 A.M with the Dietary Manager (DM) revealed there was a bottle of cleaning spray on the clean dish rack and on the clean dishes there was a piece of cardboard, a soiled rag, and an opened bottle of soda. Observation 09/08/25 at 10:25 A.M of the dry storage area with the DM revealed the following unlabeled and undated items: two bags of elbow pasta, a bag of egg noodles, a container of rolled oats, a bag of croutons. There was also a package of gravy with an expiration date of 07/07/25. Interview on 09/08/25 at 10:30 A.M with the DM confirmed items should not be stored in the clean dish area and the items in the dry storage area should be labeled and dated. The DM confirmed expired items should be discarded. Observation on 09/08/25 at 10:32 A.M of the cold storage with the DM revealed in walk in refrigerator contained the following unlabeled and undated items: a gallon container of orange juice, a gallon container of grape juice, an opened package of Swiss cheese, an opened package of cheddar cheese. The walk-in freezer contained a package of undated and unlabeled chicken nuggets. The walk-in freezer also had dirty gloves on the floor of the freezer and dried up a brown substance on the floor. Interview on 09/08/25 at 10:35 A.M with the DM confirmed items in cold storage should be labeled and dated and the gloves and dried substance on the floor of the freezer should have been cleaned. Observation on 09/08/25 at 10:36 A.M with the DM revealed the stand-up refrigerator contained the following undated and unlabeled items: 12 cups of fruit, two cups of shredded cheddar cheese, two cups of cottage cheese. Interview on 09/08/25 at 10:37 A.M. with the DM confirmed all items in the stand-up refrigerator should be labeled and dated. Observation on 09/08/25 at 10:38 A.M with the DM revealed there were unlabeled and undated containers of sugar, flour, and breadcrumbs in the kitchen prep station. Interview on 09/08/25 at 10:29 A.M with the DM confirmed the containers of sugar, flour, and breadcrumbs in the kitchen prep station were undated and unlabeled. Observation 09/08/25 at 10:30 A.M with the DM revealed the robot coupe (appliance used to puree food) had not cleaned after use and the hood above the stove had a dark, brown substance on top and on the wall. Interview on 09/08/25 at 10:31 A.M with the DM confirmed the robot coupe should have been cleaned immediately after use and stove hood and wall should have been cleaned. Observation on 09/11/25 at 11:15 A.M. with the DM revealed the air vent above the kitchen prep and serving area had a build-up of a dark fuzzy substance. Interview on 09/11/25 at 11:15 A.M. with the DM confirmed the air vent above the kitchen prep and serving area had a build-up of a dark fuzzy substance. Review of the facility policy titled Food Receiving and Storage dated on October 2017 revealed the facility staff should label and date all food items and use perishable items within seven days after opening.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to complete a significant change Pre-admission Screening and Resident Review (PASARR) assessment after residents received new diagnoses for psychiatric disorders. This affected two (Residents #7 and #76) of four residents sampled for PASARR. The facility census was 79 residents. Findings include: 1. Review of the medical record for Resident #76, revealed an admission date of 04/15/24 with diagnoses including cerebrovascular accident (CVA) with hemiplegia and hemiparesis, anxiety disorder, schizoaffective disorder, and depression. Review of the PASARR for Resident #76 dated 10/21/21 revealed it did not include a diagnosis of schizoaffective disorder. Review of the Minimum Data Set (MDS) assessment for Resident #76 dated 07/22/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Interview on 09/10/25 at 2:57 P.M. with the Administrator confirmed the facility should have completed an updated PASARR when Resident #76 was admitted on [DATE] with a diagnosis of schizoaffective disorder. 2. Review of the medical record for Resident #7 revealed an admission date of 08/03/18 with diagnoses of major depressive disorder. A diagnosis of bipolar disorder was added on 07/07/24. Review of the PASARR for Resident #7 dated 02/22/22 revealed the resident's only psychiatric diagnosis was major depressive disorder. Review of the MDS assessment for Resident #7 dated 06/18/25 revealed Resident #7 had moderately impaired cognition. Interview on 09/09/25 at 2:38 P.M. with Social Worker (SW) #476 confirmed the facility did not complete an updated PASARR in 2024 for Resident #7 when an updated diagnosis of bipolar disorder was added 07/07/24. Interview on 09/09/2025 at 3:51 P.M. with Corporate Registered Nurse (CRN) #482 confirmed the facility should complete a significant change PASARR within 72 hours of any new psychiatric diagnosis.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review, resident interview, and staff interview, the facility failed to ensure residents received timely treatment for respiratory infections. This affected one (Resident #7) of seven residents sampled for respiratory infections. The facility census was 79 residents. Findings include: Review of the medical record for Resident #7 revealed an admission date of 08/03/18 with a diagnosis of major depressive disorder. Review of the Minimum Data Set (MDS) assessment for Resident #7 dated 06/18/25 revealed the resident had moderately impaired cognition. Review of the progress note for Resident #7 dated 09/03/25 revealed the nurse practitioner (NP) assessed Resident #7 for complaints of complaint of cough for several days. Lung auscultation revealed concerns for wheezes bilaterally. The NP gave orders for a stat (immediate) chest x-ray and Tylenol cold & flu medication. Review of the physician's orders for Resident #7 revealed an order dated 09/03/25 for a stat chest x-ray. There was no written order for Tylenol cold and flu medication. Interview on 09/08/25 at 11:34 A.M. with Resident #7 confirmed he had for medicine for flu and had been having symptoms for a week or two including a cough and a runny nose. Interview on 09/10/25 at 10:00 A.M. NP #492 confirmed she had assessed Resident #7 on 09/03/25 and gave a verbal order to the nurse to implement the standing order for Tylenol cold and flu medication and to give a dose immediately. NP #492 stated she was unaware the order had not been placed and verified the Tylenol cold and flu medication was not on Resident #7's profile. This deficiency represents noncompliance investigated under Complaint Number OH00162888 (iQIES 1311544)		

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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. Based on medical record review, staff interview, and review of the facility policy, the facility failed to complete root cause analysis following resident falls. This affected one (Resident #39) of three residents reviewed for falls. The facility census was 79 residents. Findings include: Review of the medical record for Resident #39 revealed an admission date of 06/17/24 with diagnoses including Parkinson's disease, type two diabetes, depression, generalized anxiety disorder, and unspecified dementia. Review of care plan for Resident #39 dated 06/18/24 revealed the resident was at risk for falls. Interventions included anticipating resident needs, keeping the call light within reach, maintaining a safe environment, and educating the resident regarding appropriate footwear, using call light for assistance, and safe use of mobility devices. Review of the progress note for #39 dated 02/24/25 revealed the resident had an unwitnessed fall in her room. Staff found Resident #39 seated on the floor in front of her walker. Resident #39 stated she hit her head during the fall. Review of the facility incident report and investigation of Resident #39's fall on 02/24/25 revealed it did not include a root cause analysis of the events and factors leading to the resident's fall. Review of the Minimum Data Set (MDS) assessment for Resident #39 dated 06/24/25 revealed the resident was cognitively intact, had no behaviors, did not wander, and did not reject care. Interview on 09/11/25 at 10:00 A.M. with the Director of Nursing (DON) confirmed the facility did not complete a root cause analysis of Resident #39's fall on 02/24/25. The DON confirmed part of the facility's fall investigation process should include a root cause analysis. Review of the facility policy titled Managing Falls and Fall Risk dated December 2007 revealed the facility evaluated falls and identified interventions related to the resident's specific risks and causes to try to prevent the resident from falling. This deficiency represents noncompliance investigated under Complaint Number OH00162646 (1311543).		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure the medication error rate was less than five percent (%). The facility had three medication errors per 25 medication opportunities with a medication error rate of 12 %. This affected two (Residents #2 and #44) of three residents observed for medication administration. The facility census was 79 residents. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 03/13/24 with diagnoses including anxiety disorder, congestive heart failure (CHF), and type two diabetes mellitus. Review of the physician's order for Resident #2 revealed an order dated 03/13/24 for spironolactone 25 milligrams (mg), give one tablet by mouth one time a day for hypertension and an order dated 03/13/24 for cyanocobalamin 100 micrograms (mcg), give one tablet by mouth one time per day. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 08/19/25 revealed the resident was cognitively intact and required supervision with activities of daily living (ADLs.) Observation on 09/09/25 at 8:32 A.M. revealed Licensed Practical Nurse (LPN) #310 did not administer spironolactone and cyanocobalamin to Resident #2 because the medications were not available. Interview on 09/09/25 at 8:58 A.M. with LPN #310 verified Resident #2's spironolactone and cyanocobalamin were not available to administer. 2. Review of the medical record for Resident #44 revealed an admission date of 10/31/24 with diagnoses including chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, and depression. Review of the physician's orders for Resident #44 revealed an order dated 11/11/24 Novolog insulin per sliding scale inject subcutaneously. Review of the MDS assessment for Resident #44 dated 08/07/25 revealed the resident was cognitively intact and required assistance with ADLs. Observation on 09/09/25 at 12:14 P.M. revealed LPN #313 not prime the insulin pen prior to administering four units of insulin to Resident #44. Interview on 09/09/25 at 12:25 P.M. with LPN #313 verified she did not prime insulin pen with two units prior to administration to Resident #44. Review of the facility policy titled Administering Medications dated April 2019 revealed medications were administered in a safe and timely manner, and as prescribed. Medication errors were documented in the medical record, reported to the provider and resident/resident representative, and the resident was monitored for adverse effects of the medication error as ordered by the provider.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of the medical record review, observation, staff interview, and review of manufacturer's instructions, the facility failed to prime an insulin pen prior to administration. This affected one (Resident #44) of one observed for insulin administration and had the potential to affect two residents on medication cart one on the east hall with physician orders for insulin. The facility census was 79 residents. Findings include: Review of the medical record for Resident #44 revealed an admission date of 10/31/24 with diagnoses including chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, and depression. Review of the Minimum Data Set (MDS) assessment for Resident #44 dated 08/07/25 revealed the resident had intact cognition and required assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #44 revealed an order dated 11/11/24 Novolog insulin inject subcutaneously per sliding scale. Observation on 09/09/25 at 12:14 P.M. of medication administration revealed Licensed Practical Nurse (LPN) #313 did not prime the Novolog insulin pen prior to administering four units of insulin to Resident #44. Interview on 09/09/25 at 12:25 P.M. with LPN #313 verified she did not prime the insulin pen with two units prior to administration. Review of the insulin pen instructions titled Using Insulin Pens and Pen Needles revealed prior to administration one should always prime the insulin pen before each injection. Dial two units on the pen and then press the button to shoot some insulin into the air to make sure it worked. This was called an air shot or priming the pen. If you did not see at least two drops of insulin after repeated priming, do not use the pen.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff interview, and review of the facility policy, the facility failed to measure correct portion sizes to meet resident nutritional needs. This affected one (Resident #73) of one resident with physician's orders for a pureed diet. The facility census was 79 residents. Findings include: Observation of food preparation on 09/11/25 at 11:02 A.M revealed Dietary Staff (DS) #404 used a spatula to scoop pureed stuffed peppers onto Resident #73's plate. Interview on 09/11/25 at 11:03 A.M with DS #404 confirmed Resident #73 was on a pureed diet, and he used a spatula to plate the pureed stuffed peppers for the resident because he did not have the proper scoop. Observation on 09/11/25 at 11:15 A.M revealed DS #404 used a three-ounce scoop when plating Resident #73's mashed potatoes. Interview on 09/11/25 at 11:20 A.M with DS #404 confirmed he used a three-ounce scoop when plating Resident #73's mashed potatoes, but the recipe called for a four-ounce portion of mashed potatoes. DS #404 confirmed he used the three-ounce scoop, because he did not have a four-ounce scoop on hand. Review of the facility policy titled Kitchen Weights and Measurements dated April 2007 revealed that the facility should use proper measurements for portion control of foods.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure staff maintained sterile technique during tracheostomy care. This affected one (Resident #11) of one resident sampled for tracheostomy care. The facility also failed to ensure staff wore the appropriate personal protective equipment (PPE) for residents on Enhanced Barrier Precautions (EBP). This affected one (Resident #12) of 13 residents reviewed for EBP. The facility census was 79 residents. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 06/13/25 with diagnoses including anoxic brain damage, anxiety disorder, tracheostomy status, and schizophrenia. Review of the physician's orders for Resident #11 revealed an order dated 06/14/25 for tracheostomy care every day and night shift and as needed. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 08/08/25 revealed the had severe cognitive impairment and was dependent on staff with activities of daily living (ADLs), and had a tracheostomy. Review of the care plan for Resident #11 dated 09/08/25 revealed the resident was at risk for developing complications secondary to altered respiratory status/difficulty breathing related to tracheostomy status, chronic respiratory failure. Interventions included the following: deliver three liters of oxygen via trach mask may titrate to keep oxygen saturation levels above 90 percent (%) every shift as ordered, administer medications and nebulizers as ordered, avoid lying flat due to shortness of breath, monitor and document changes in orientation, increased restlessness, anxiety, and air hunger. Observation of tracheostomy care for Resident #11 on 09/11/25 at 10:02 A.M. per Licensed Practical Nurse (LPN) #310 revealed when setting up the sterile field for trach care, the nurse used clean gloves to place all sterile items onto the field including the sterile gloves. LPN #310 did not remove clean gloves prior to donning sterile gloves. LPN #310 provided trach care to Resident #11 with contaminated sterile medical supplies. Interview on 09/11/25 at 10:23 A.M. with LPN #310 verified she touched all sterile items with clean gloves and then placed sterile gloves over top of clean gloves before providing trach care to Resident #11. 2. Review of the medical record for Resident #12 revealed an admission date of 04/26/24 with diagnoses including anoxic brain damage, chronic respiratory failure with hypoxia, affective mood disorder, and hemiplegia and hemiparesis following cerebral infarction. Review of care plan for Resident #12 dated 05/08/24 revealed the resident was on EBP secondary to increased risk for infection related to tube feeding. Interventions included staff should follow EBP when providing care. Review of the MDS assessment for Resident #12 dated 06/30/25 revealed the resident had severely impaired cognition. Observation on 09/10/2025 at 11:21 A.M. of incontinence care for Resident #12 per Certified Nursing Assistants (CNAs) #221 and #298 revealed the aides wore gloves, but neither CNA was wearing an isolation gown. There was a sign on Resident #12's door which indicated staff were to wear gloves and isolation gowns when performing direct care. Interviews on 09/10/25 at 11:22 A.M. with CNAs #298 and #221 confirmed they did not wear isolation gowns while performing care for Resident #12. Review of the policy titled Enhanced Barrier Precautions dated August 2022 revealed examples of high-contact activities that required the use of gown and gloves included bathing, providing hygiene, changing briefs, and assisting with toileting.		