STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365081	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Healthcare Center	7800 Jandaracres Drive Cincinnati, OH 45248

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, observation, resident interview, staff interview, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to timely report an allegation of abuse to the state agency. This affected one (Resident #1) of three residents reviewed for abuse. The facility census was 101 residents. Findings include: Review of the medical record for Resident #1 revealed an admission date of 11/14/20 with diagnoses including right sided hemiplegia and hemiparesis following cerebral infarction and hypertension.Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 07/10/25 revealed the was cognitively intact and required staff assistance with activities of daily living (ADLs.)Review of the skin assessments for Resident #1 dated 11/05/25 and 11/08/25 revealed there were no new areas of skin impairment noted.Review of the facility SRI for Resident #1 initiated 11/13/25 at 2:35 P. M. revealed the resident reported staff had been rough with her while providing care on 11/08/25 or 11/09/25. CNA #66 was suspended on 11/13/25 pending investigation. The facility was unable to determine if abuse had occurred as the evidence was inconclusive. The facility notified local police of the allegation and educated all staff on the abuse policy. Observation on 11/13/25 at 10:20 A.M. of Resident #1 revealed the resident had four discolored markings on her left forearm. Interview on 11/13/25 at 11:15 A.M. with Resident #1 confirmed the aides had been rough with her during a transfer from chair to bed on 11/08/25. Resident #1 confirmed staff had grabbed her by the left arm and that she had asked the Certified Nursing Assistant (CNA) assisting with the transfer to stop because it was hurt. Resident #1 confirmed she reported the incident to staff on 11/09/25. Interview on 11/13/25 at 1:47 P.M. with Licensed Practical Nurse LPN #3 confirmed on 11/08/25 Resident #1 complained of bruising to the left arm but was confused about how the bruises had occurred. LPN #3 confirmed she notified the on-call provider and obtained an order to collect a urine sample to rule out a urinary tract infection (UTI.) LPN #3 confirmed she then reported the conversation with Resident #1 to Registered Nurse (RN) #51 and CNA #66. During an interview on 11/13/25 at 2:05 P.M., CNA #66 denied having been rough with Resident #1 and thought the bruising on the resident's arms had been discovered in the shower room on the previous Wednesday. Interview on 11/13/25 at 2:26 P.M. with the Administrator confirmed the facility had not reported an allegation of abuse or mistreatment towards Resident #1 to the state agency. Interview on 11/17/25 at 10:24 A.M. with RN #51 confirmed he received a report on 11/09/25 from LPN#3 that there were markings on Resident #1's left forearm and the resident was confused about how they had occurred. RN #51 confirmed on 11/08/25 he notified the Administrator via telephone of Resident #1's concerns, but the Administrator had not directed the nurse to take any further action. Interview on 11/17/25 at 12:26 P.M. with CNA #35 confirmed Resident #1 notified her on 11/08/25 that CNA #66 had hurt her arm and described being pushed left and right. Resident #1 stated she CNA #66 she was hurting but the aide continued pushing her. CNA #35 confirmed she told LPN #3, LPN #79, and RN #51 of Resident #1's allegations against CNA #66. CNA #35 confirmed she then received a phone call from the Administrator regarding Resident #1's allegation. Interview on 11/17/25 at 11:28 A.M. with the Administrator confirmed he received a report from CNA#35 on 11/09/25 that Resident #1 had alleged CNA#66 was rough while providing care on 11/08/25. The Administrator confirmed RN #51 reported Resident #1's concerns regarding rough care to him on 11/09/25 at 3:00 P.M. The Administrator confirmed the facility did not report Resident #1's allegation of rough treatment on 11/08/25 to the state agency until 11/13/25 after discussion with the Surveyor. Interview on 11/17/25 at 3:03 P.M. with the Director of Nursing (DON) confirmed she was not aware of Resident 1's allegation until it was reported to facility administration by the Surveyor on 11/13/25 at 2:26 P.M. The DON confirmed allegations of abuse should be reported up to the Administrator following the chain of command. Review of the facility policy titled Ohio Abuse, Neglect and Misappropriation undated revealed the facility should investigate and report injuries of unknown origin which included injuries in which the source of the injury was not observed by any person and the source of the injury could not be explained by the resident. The facility should report alleged violations of mistreatment which did not result in serious bodily injury to the state agency no later than 24 hours. This deficiency represents noncompliance investigated under Complaint Number 2650862.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, observation, resident interview, staff interview, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to initiate an investigation of an abuse allegation in a timely manner and failed to protect residents during an abuse investigation. This affected one (Resident #1) of three residents reviewed for abuse. The facility census was 101 residents. Findings include: Review of the medical record for Resident #1 revealed an admission date of 11/14/20 with diagnoses including right sided hemiplegia and hemiparesis following cerebral infarction and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 07/10/25 revealed the was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the skin assessments for Resident #1 dated 11/05/25 and 11/08/25 revealed there were no new areas of skin impairment noted.Review of the facility SRI for Resident #1 initiated 11/13/25 at 2:35 P.M. revealed the resident reported staff had been rough with her while providing care on 11/08/25 or 11/09/25. CNA #66 was suspended on 11/13/25 pending investigation. The facility was unable to determine if abuse had occurred as the evidence was inconclusive. The facility notified local police of the allegation and educated all staff on the abuse policy. Observation on 11/13/25 at 10:20 A.M. of Resident #1 revealed the resident had four discolored markings on her left forearm. Interview on 11/13/25 at 11:15 A.M. with Resident #1 confirmed the aides had been rough with her during a transfer from chair to bed on 11/08/25. Resident #1 confirmed staff had grabbed her by the left arm and that she had asked the Certified Nursing Assistant (CNA) assisting with the transfer to stop because it was hurt. Resident #1 confirmed she reported the incident to staff on 11/09/25. Interview on 11/13/25 at 1:47 P.M. with Licensed Practical Nurse LPN #3 confirmed on 11/08/25 Resident #1 complained of bruising to the left arm but was confused about how the bruises had occurred. LPN #3 confirmed she notified the on-call provider and obtained an order to collect a urine sample to rule out a urinary tract infection (UTI.) LPN #3 confirmed she then reported the conversation with Resident #1 to Registered Nurse (RN) #51 and CNA #66. During an interview on 11/13/25 at 2:05 P.M., CNA #66 denied having been rough with Resident #1 and thought the bruising on the resident's arms had been discovered in the shower room on the previous Wednesday. Interview on 11/13/25 at 2:26 P.M. with the Administrator confirmed the facility had not reported an allegation of abuse or mistreatment towards Resident #1 to the state agency, had not initiated an investigation of the abuse allegation, and had not taken steps to protect residents during the course of the investigation, such as suspending alleged perpetrators of abuse from working with residents. Interview on 11/17/25 at 10:24 A.M. with RN #51 confirmed he received a report on 11/09/25 from LPN#3 that there were markings on Resident #1's left forearm and the resident was confused about how they had occurred. RN #51 confirmed on 11/08/25 he notified the Administrator via telephone of Resident #1's concerns, but the Administrator had not directed the nurse to take any further action. Interview on 11/17/25 at 12:26 P.M. with CNA #35 confirmed Resident #1 notified her on 11/08/25 that CNA #66 had hurt her arm and described being pushed left and right. Resident #1 stated she CNA #66 she was hurting but the aide continued pushing her. CNA #35 confirmed she told LPN #3, LPN #79, and RN #51 of Resident #1's allegations against CNA #66. CNA #35 confirmed she then received a phone call from the Administrator regarding Resident #1's allegation. Interview on 11/17/25 at 11:28 A.M. with the Administrator confirmed he received a report from CNA#35 on 11/09/25 that Resident #1 had alleged CNA#66 was rough while providing care on 11/08/25. The Administrator confirmed RN #51 reported Resident #1's concerns regarding rough care to him on 11/09/25 at 3:00 P.M. The Administrator confirmed the facility did not report Resident #1's allegation of rough treatment on 11/08/25 to the state agency until 11/13/25 after discussion with the Surveyor. The Administrator confirmed CNA #66, the alleged perpetrator of abuse towards Resident #1 was not suspended pending investigation until after the survey was entered. Interview on 11/17/25 at 3:03 P.M. with the Director of Nursing (DON) confirmed she was not aware of Resident 1's allegation until it was reported to facility administration by the Surveyor on 11/13/25 at 2:26 P.M. The DON confirmed allegations of abuse should be reported up to the Administrator following the chain of command. Review of the facility policy titled Ohio Abuse, Neglect and Misappropriation undated revealed the facility should investigate and report injuries of unknown origin which included injuries in which the source of the injury was not observed by any person and the source of the injury could not be explained by the resident. The facility should report alleged violations of mistreatment which did not result in serious bodily injury to the state agency no later than 24 hours. The facility should investigate all allegations of abuse and should take measures to protect