STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365178	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenwood Terrace Healthcare Center	7450 Keller Road Cincinnati, OH 45243

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51520 Based on medical record review and resident and staff interview, the facility failed to promote and honor a resident's choice for bathing. This affected one (#21) of two residents reviewed for activities of daily living (ADLs). The facility census was 82. Findings include: Review of Resident #21's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis, thrombocytopenia purpura, chronic kidney disease stage II, hypertension, chronic pain syndrome, osteoarthritis, diverticulosis, gastro-esophageal reflux, vascular dementia, hyperlipidemia, and visual disturbance. Review of Resident #21's admission Minimum Data Set (MDS) assessment dated [DATE] and the annual MDS assessment dated [DATE] revealed the choice of bathing options was very important to the resident. Review of the most recent MDS assessment dated [DATE] revealed Resident #21 was cognitively intact. Review of Resident #21's shower sheets for December 2024, January 2025, and February 2025 revealed the resident received only four showers between 12/-6/24 and February 2025. Further review revealed the resident received bed baths 13 times in that same time period, and three shower sheets dated 01/03/25, 01/20/25, and 01/17/25 were not completed and did not identify what type of bathing was provided. Review of a social services note dated 01/02/25 at 12:28 P.M. revealed Social Worker (SW) #125 and the Executive Director (ED) met with Resident #21 to discuss the shower schedule and any other concerns SW #125 and the ED encouraged the resident to use the appropriate pathways if she did not feel she was getting the care she needed which started by letting the nursing staff know and then calling the front desk to get in contact with the Director of Nursing (DON), the ED or social worker at the time of need so Resident #21 was ensured to get the care requested. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #21 on 02/10/25 at 8:37 P.M. revealed she has not received regular baths or showers. Resident #21 revealed she wanted to consistently receive showers two times weekly. Resident #21 revealed staff gave her bed baths despite her requests for showers. Follow up interview with Resident #21 on 02/12/25 at 10:37 A.M. confirmed she rarely received showers and was mostly given bed baths. Resident #21 stated her bathing days are on Tuesday and Saturday and verified she preferred getting showers over bed baths because she does not feel they get her clean enough. Interview with Certified Nurse Aide (CNA) #532 on 02/12/25 at 9:18 A.M. confirmed Resident #21 received showers on occasion but mostly received bed baths. This deficiency represents non-compliance investigated under Complaint Number OH00161944.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51520 Based on medical record review and staff interview, the facility failed to complete discharge Minimum Data Set (MDS) assessments in a timely manner. This affected two (#63 and #82) of three residents reviewed for resident assessments. The facility census was 82. Findings include: 1. Review of Resident #63's medical record revealed the resident was admitted to the facility on [DATE] and discharged to home on 10/09/24. Diagnoses included chronic obstructive pulmonary disease, urinary tract infections, malignant neoplasm of the larynx, pulmonary insufficiency, acute kidney failure, protein-calorie malnutrition, gastronomy, adult failure to thrive, dysphagia, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had intact cognition with no behavior symptoms. Review of the medical record revealed Resident #63 discharged from the facility on 10/09/24 to home with proper discharge. Further review revealed a discharge MDS assessment was not completed and was overdue. 2. Review of Resident #82's medical record revealed the resident was admitted to the facility on [DATE] and discharged to home on 10/23/24. Diagnoses included spinal fusion, bacteremia, thyroid disorder, sleep apnea, dysphagia, hypoxemia, gastronomy, muscle weakness, gastro-esophageal reflux disease, and cognitive communication deficit. Review of the quarterly MDS assessment dated [DATE] revealed Resident #82 had intact cognition with no behavior symptoms. Review of the medical record revealed Resident #82 discharged from the facility on 10/23/24 to home with proper discharge. Further review revealed a discharge MDS assessment was not completed and was overdue. Interview with MDS Nurse #495 on 02/12/25 at 11:30 A.M. verified discharge MDS assessments were not completed timely for Resident #63 and Resident #82.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, resident and staff interviews, and policy review, the facility failed to ensure care conferences were held as required for residents and their representatives. This affected two (#12 and #38) of three residents reviewed for care conferences. The facility census was 82. Findings include: 1. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses of end stage renal disease (ESRD) with dependence on hemodialysis, diabetes mellitus type II, cerebrovascular accident (CVA) with left (dominate) side hemiplegia/hemiparesis, congestive heart failure (CHF), and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had no cognitive impairment and was frequently incontinent of bowel and bladder. The resident required set up assistance for eating, maximal assistance for oral hygiene and bed mobility, and was dependent for personal hygiene, toileting, bathing, dressing and transfers. Review of the documentation provided by the Regional Director of Clinical Operations #3030 revealed Resident #12 or her representative were offered care conferences in the third quarter (July, August, and September) and attended on 08/23/24. There was no documented evidence that a care conference was offered or completed with the resident/representative for the second quarter (April, May or June) or fourth quarter (October, November or December) of 2024. Interview on 02/13/25 at 8:30 A.M. with Resident #12 revealed no knowledge of the facility discussing her care with her at any time. Interview on 02/13/25 at 9:55 A.M. with RDCO #3030 verified the facility had no documentation that a care conference was conducted with Resident #12 or her representative during the second quarter (April, May, or June) and fourth quarter (October, November, or December) of 2024. 2. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), hypertensive heart and chronic kidney disease, atrial fibrillation, diabetes mellitus type II, obstructive and reflux uropathy, and metabolic encephalopathy. Review of the annual MDS assessment dated [DATE] revealed Resident #38 had moderate cognitive impairment, had an indwelling urinary catheter, and was always incontinent of bowel. The resident was dependent for eating, oral and personal hygiene, toileting, bathing, dressing, bed mobility, and transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the documentation provided by the RDCO #3030 revealed Resident #38 or his representative were offered care conferences in the third (July, August, and September) and fourth (October, November, and December) quarters of 2024 and attended on 09/18/24 and 12/18/24. There was no documented evidence that a care conference was offered or completed with the resident or the resident's representative for the first quarter (January, February, or March) and second quarter (March, April, or May) of 2024. Interview on 02/13/25 at 9:55 A.M. with RDCO #3030 verified the facility had no documentation that a care conference was conducted with Resident #38 or his representative during the first quarter (January, February, or March) and second quarter (April, May, or June) of 2024. Review of the undated policy titled, Plan of Care Overview, revealed residents/representatives will be informed of their Plan of Care (POC) in the most understandable manner possible. Residents/representatives will be offered opportunities to voice their view. The facility will review care plans quarterly and/or with significant changes in care and will support the residents right to participate in treatment and care planning. Care plan documents will be maintained in electronic form or paper form and attendees will sign and date care plan meeting agendas/documents.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on medical record review and staff interviews, the facility failed to ensure residents were administered antipsychotic medications for appropriate indications. This affected two (#84 and #241) of the five residents reviewed for unnecessary medications. The facility census was 82. Findings include: 1. Record review for Resident #241 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included end stage renal disease, gout, and anemia. There were no diagnoses with indications for use of an antipsychotic medication in the medical record. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/06/24, revealed Resident #241 was assessed to have intact cognition. Review of the active physicians order dated 01/27/25 revealed Resident #241 was to be administered 25 milligrams (mg) of Seroquel (an antipsychotic medication) once a day in the mornings. There were no indication for the use of the medication present. Interview with Divisional Director of Clinical Operations (DDCO) #850 on 02/13/25 at 10:49 A.M. confirmed Resident #241 received Seroquel without adequate indications for use. 49771 2. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE] with diagnoses of Alzheimer's dementia, cerebrovascular accident (CVA) with right (dominant) side hemiplegia/hemiparesis, and diabetes mellitus type II. Review of the MDS admission assessment dated [DATE] revealed Resident #84 had severe cognitive impairment and was frequently incontinent of bowel and bladder. Review of physician orders revealed an order dated 11/30/24 for Resident #84 to be administered the antipsychotic olanzapine five (5) mg with instructions to give one tablet by mouth at bedtime for insomnia. Review of the medication administration record (MAR) for December 2024, January 2025, and February 2025 revealed Resident #84 was administered olanzapine 5 mg as ordered. Interview on 02/13/25 at 12:15 P.M. with the Director of Nursing verified Resident #84 did not have an appropriate diagnosis indicated for use of olanzapine.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51520 Based on medical record review, staff interview, review of a facility policy, the facility failed to a physician was notified promptly of a critical laboratory value. This affected one (#16) of three residents reviewed for change in condition. The facility census was 82. Findings include: Review of Resident #16's medical record revealed an admitted [DATE] with diagnoses of diabetes mellitus type II with diabetic polyneuropathy, chronic obstructive pulmonary disease (acute) with lower respiratory infection, and muscle weakness (generalized). Review of the admission Minimum Data Set (MDS) assessment, dated 11/04/2024, revealed Resident #16 had moderate impairment in cognition. Review of a Telehealth notification note dated 07/15/24 (6:00 P.M.) revealed Resident #16 felt lightheaded and dizzy after going out to smoke. The resident's vital signs and blood sugar were checked at that time. Orders were placed to obtain a complete blood count (CBC) and comprehensive metabolic panel (CMP) laboratory work. The laboratory work was completed on 07/16/24 at 7:46 A.M. and results were reported on 07/16/24 at 6:22 P.M. Review of Resident #16's laboratory results revealed the resident had a critically low blood sugar level. Review of the progress note date 07/17/24 at 12:21 P.M. revealed the Medical Director was notified of Resident #16's critical laboratory results from 07/16/24. A new order was received for the resident to have fasting blood sugar checked every morning at 6:00 A.M. and at bedtime. Further review of Resident #16's medical record revealed no evidence of a physician being notified of the critically low blood sugar level on 07/26/24 at 6:22 P.M. until the Medical Director was notified on 07/24/24 at 12:21 P.M. Interview with the Director of Nursing (DON) on 02/12/25 at 3:15 P.M. verified there was no documentation of a physician being promptly notified of Resident #16's critical laboratory value on 07/16/24. Review of the undated facility policy titled, Critical Laboratory Value Management, revealed when critical values are obtained in any method, the nurse will place a call to the ordering physician and will document the time, the number called, and to whom a message was given. The resident/representative will also be contacted for changes in condition, if applicable.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on observation, resident and staff interview, and medical record review, the facility failed to ensure residents were provided with prompt and appropriate dental services upon the discovery of a resident with missing dentures. This affected one (#62) of six residents reviewed for personal property. The facility census was 82. Findings include: Review of Resident #62's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included schizoaffective bipolar disorder, depression, dysphagia, extrapyramidal and movement disorder, cognitive communication disorder, difficult ambulation, muscle weakness, dementia, gastro-esophageal reflux disease, and hyperlipidemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had minimal cognitive impairments with no behavior symptoms. Review of Resident #62's medical record contained no item inventory list upon admission to determine if the resident had full set of dentures upon arrival to the facility. Review of dental notes revealed Resident #62 was last seen by a dental provider on 10/22/24 as a follow up. Further review revealed the dental assessments provided no proposed treatment for missing lower dentures. Review of dietary progress notes documented on 12/20/24 at 1:54 P.M. revealed Resident #62 reported occasional difficulty chewing tough or hard foods due to long-term absence of bottom dentures. Further review of Resident #62's medical record revealed no document evidence of the facility arranging for dental services at least as far back as 12/20/24 when it was revealed in the dietary progress notes the resident reported absence of bottom dentures to staff. Interview and observation with Resident #62 on 02/10/25 at 7:49 P.M. revealed the resident had missing bottom dentures and was only wearing top dentures. The resident did not know what happened to the bottom dentures and could not rule out someone taking them. Follow up interview and observation of Resident #62 on 02/13/25 at 10:39 A.M. revealed she was admitted to the facility with both upper and lower dentures and could not remember when the dentures went missing but staff were unable to find them. Resident #62 further denied pain or weight loss as a result of the missing dentures. Observation of Resident #62 at that time revealed the resident did not have bottom dentures. Interview with Regional Director of Clinical Services #3030 on 02/13/25 at 9:45 A.M. verified the facility could not provide any further documentation in regards to Resident #62 having missing dentures or arranging for dental services once staff were informed the dentures were missing.

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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. 51520 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure food was stored in a safe manner and failed to ensure kitchen equipment was kept in a clean and sanitary manner. This had the potential to affect all 82 residents residing in the facility. The facility census was 82. Findings include: Observation on 02/10/25 at 6:45 P.M. of the facility kitchen revealed the walk-in refrigerator contained marinara sauce and two whipped toppings without expiration dates. The freezer had opened cauliflower without an expiration date. Observation of the pantry revealed open raisin bran, toasted oats, marshmallows, and cornbread without an expiration date. On the spice shelf above the preparation station was a container of oregano with an expiration date of 09/28/23. Observation of the kitchen dry storage area on 02/10/25 at 6:50 P.M. revealed cans of mandarin oranges and pumpkin that were severely dented and placed on the shelf indicated for facility use. Further observation at 7:01 P.M. revealed a large amount of debris with a strong odor in the microwave. Interview on 02/10/25 with Executive Chef (EC) #10 between 6:45 P.M. and 7:01 P.M. confirmed the aforementioned food items were not properly dated, verified the dented cans in dry storage, and confirmed the appearance of the microwave. EC #10 stated dented cans were supposed to go on the bottom shelf to be sent back and not on the shelves to be used and stated the microwave was supposed to be cleaned once a shift. Review of the facility policy titled, Food Preparation-Food Storage, dated 08/20/18, revealed all food should be stored in a sealed container and should be labeled and dated.