

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Madeira		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 Kenwood 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a clean, comfortable and homelike environment for residents. This affected six residents (#04, #11, #15, #19, #39, and #86) out of 15 residents reviewed for physical environment. The facility census was 86. Findings include: 1. Review of the medical record of Resident #19 revealed an admission date of 10/10/24. Diagnoses included chronic obstructive pulmonary disease, urinary tract infection, and chronic respiratory failure with hypoxia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require setup or cleanup assistance for eating, setup or cleanup assistance for oral hygiene, substantial/maximal assistance for toileting, substantial/maximal assistance for shower/bathing, dependent for dressing, and substantial/maximal assistance for personal hygiene.</p> <p>Observation on 12/10/25 at 8:40 A.M revealed Resident #19 had a dirty brief laying on the floor next to her bed.</p> <p>Interview on 12/10/25 at 8:45 A.M with Resident #19 confirmed Resident #19 took her brief off and left it on the floor around 7:00 A.M.</p> <p>Interview on 12/10/25 at 8:50 A.M with Licensed Practical Nurse (LPN) #28 confirmed Resident #19 had a dirty brief lying next to her bed.</p> <p>2. Record review for Resident #39 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: type two diabetes mellitus with diabetic neuropathy, diabetes mellitus, and unsteadiness of feet.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require a wheelchair of mobility.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/09/25 at 12:00 P.M. revealed Resident #39's room had a window curtain that was hooked randomly on the curtain rod, creating loose gaps at the top. The curtain lining was not attached at the side and lower seams, with the hem of the curtain hanging loose in random areas along the bottom edge. The curtain was faded and wrinkled. There was a drawer front missing on a dresser, a broken glass picture frame on the wall with shards of glass within the frame. There was unattached wallpaper in the bathroom of about six feet long along the baseboard. There was a two-foot-long plastered area directly above the resident's bed, unpainted.</p> <p>Interview on 12/09/25 at 12:00 P.M. with Resident #39 stated the worn curtain, broken glass picture frame , unpainted wall area and missing drawer front made for an unsightly and unhomelike room.</p> <p>Interview on 12/11/25 at 3:10 P.M. with Environmental Director (ED) #3 verified Resident #39 had unpainted plastered wall, loose wallpaper in bathroom, missing dress drawer front and broken glass picture frame on the wall with shards of loose glass. He further verified the curtains were so worn the hem stiches were no longer attached, that the curtains were on the curtain rod incorrectly and were very wrinkled. The ED #3 stated the curtains needed replaced or repaired.</p> <p>3. Record review for Resident #15 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: lymphedema, gastro-esophageal reflux disease without esophagitis, morbid obesity and hyperlipemia.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident used a walker and wheelchair for mobility.</p> <p>Observation on 12/09/25 at 12:15 P.M. revealed Resident #15's room had a window curtain that was hooked randomly on the curtain rod, creating loose gaps at the top. The curtain lining was not attached at the side and lower seams, with the hem of the curtain hanging loose in random areas along the bottom edge. The curtain was faded and wrinkled.</p> <p>Interview on 12/09/25 at 12:015 P.M. with Resident #15 stated the worn and wrinkled curtain was unsightly and felt like the staff didn't care to take the time to make it look right.</p> <p>Interview on 12/11/25 at 3:10 P.M. with Environmental Director (ED) #3 verified the curtains in Resident #15's room were so worn the hem stiches were no longer attached, that the curtains were on the curtain rod incorrectly and were very wrinkled. The ED #3 stated the curtains needed replaced or repaired.</p> <p>4. Record review for Resident #86 revealed the resident was admitted to the facility 09/20/24. Diagnoses included chronic obstructive pulmonary disease, diabetes, morbid obesity, hypertension, and atrial fibrillation.</p> <p>Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed the resident had intact cognition and required maximal assistance.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/09/25 at 12:25 P.M. revealed Resident #86's room had a window curtain that was hooked randomly on the curtain rod, creating loose gaps at the top. The curtain lining was not attached at the side and lower seams, with the hem of the curtain hanging loose in random areas along the bottom edge. The curtain was faded and wrinkled.</p> <p>Interview on 12/09/25 at 12:25 P.M. with Resident #86 revealed the wrinkled and unattached curtain was unsightly and not like he would have had at home.</p> <p>Interview on 12/11/25 at 3:10 P.M. with Environmental Director (ED) #3 verified the curtains in Resident #86's room were so worn the hem stitches were no longer attached, that the curtains were on the curtain rod incorrectly and were very wrinkled. The ED #3 stated the curtains needed replaced or repaired.</p> <p>5. Review of the medical record of Resident #04 revealed an admission date of 07/23/20. Diagnoses included paraplegia, bipolar disorder, anxiety, depression, panic disorder, nicotine dependence, schizophrenia, opioid dependence, cocaine abuse.</p> <p>Review of the quarterly Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition. The resident was independent with eating, required substantial/maximal assistance with bed mobility and was dependent with transfers, bathing, and dressing.</p> <p>Observation on 12/08/25 at 3:09 P.M. in Resident #04's room, revealed two fabric softener sheets in the vents of the air conditioning unit. Further observation revealed varying sizes of food debris within the air conditioning unit. Continued observation revealed brownish/red splatters, measuring approximately 0.5 to 2.0 inches on the walls near the resident's television stand. Some of the areas were breaking down, exposing dry wall. The back of the door to the resident's room contained numerous areas of brown splattered material. There was an area on the floor in the corner of the room near the television stand, measuring approximately 6 inches by 4 inches, of a black substance.</p> <p>Interview at the time of the observations with Resident #04 stated the fabric softener sheets were a little trick his mom taught him. Resident #04 stated the splatters throughout the room had been that way since he moved into the room and he had attempted to clean some of the areas on the wall by himself, which caused the wall to breakdown and expose the drywall. Resident #04 stated staff told him a resident who previously resided in the room often spit blood on the floor, contributing to the black area on the floor.</p> <p>Interview on 12/08/25 at 3:29 P.M. with Maintenance Technician (MT) #137 and Maintenance Director (MD) #138 verified the splattered areas, exposed areas of drywall throughout the room, and black area in the corner.</p> <p>Interview on 12/10/25 at 2:16 P.M. with Licensed Practical Nurse (LPN) #28 verified the fabric softener sheets and food debris in Resident #04's air conditioning unit.</p> <p>6. Review of the medical record of Resident #11 revealed an admission date of 04/15/21. Diagnoses included dysphagia, type two diabetes mellitus, dementia with behavioral disturbance, hypothyroidism, hypertension, and gastro-esophageal reflux disease.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident required setup/cleanup assistance with eating, substantial/maximal assistance for bed mobility and transfers, and was dependent for toileting and bathing.</p> <p>Observation on 12/08/25 at 11:17 A.M. revealed areas of brown splatter throughout the window shade in Resident #11's room.</p> <p>Interview on 12/10/25 at 2:15 P.M. with Resident #11 stated the brown splatter on his window shade had been like that since he moved into the room over four years ago. The resident stated nobody ever cleaned his window shade.</p> <p>Interview on 12/10/25 at 2:15 P.M. with Licensed Practical Nurse (LPN) #28 verified the brown splatter throughout the shade on Resident #11's window.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers 2627584, 2590032, 1264367, and 1264360.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure care and services were provided as planned and ordered. This affected one (Resident #15) out of three reviewed. The facility census was 86. Findings include: Record review for Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses included lymphedema, gastro-esophageal reflux disease without esophagitis, and hyperlipemia.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Review of active physician orders revealed Resident #15 was ordered to have lymphedema boots placed on the resident by nursing staff for one hour two times a day for swelling reduction.</p> <p>Review of the October, November and December 2025 Medication Administration Record, (MAR), revealed there were two time slots for documentation for morning and nighttime. The slots did not have a time duration of one hour and there was random documentation of either on or off in the documentation slots.</p> <p>Review of the physician visit note dated 11/06/25, revealed Resident #15 had a diagnosis of lymphedema and reported her lymphedema boots were not being applied consistently. The physician's recommendation was to ensure the use of lymphedema boots.</p> <p>Observation on 12/08/25 from 8:00 A.M. through 4:00 P.M., revealed Resident #15 had no lymphedema boots applied during day shift.</p> <p>Interviews on 12/08/25 at 4:00 P.M., 12/09/25 at 4:05 P.M., and 12/10/25 at 3:25 P.M., Resident #15 verified she had no lymphedema boots applied during day shift or the previous night shift twice daily for one hour on 12/08/25, 12/09/25 or 12/10/25. She stated she could not put the boots on herself, and she had to be in bed near the lymphedema boot machine to receive the treatment. She stated she never has the boots applied on the evening shift or during the night. She stated sometimes the Certified Nursing Assistants (CNA) apply the boots without the nurse. Resident #15 stated she never refused the boot application.</p> <p>Observation on 12/09/25 from 8:00 A.M. through 4:00 P.M., revealed Resident #15 had no lymphedema boots applied during day shift.</p> <p>Observation on 12/10/25 from 6:10A.M. through 11:30 A.M., revealed Resident #15 had no lymphedema boots applied. At 11:40 A.M., after the surveyor brought it to the attention of Licensed Practical Nurse (LPN) # 37, then LPN #37 applied the lymphedema boots.</p> <p>Interview on 12/15/25 at 10:30 A.M., Resident #15 revealed she had no lymphedema boots applied on 12/13/25 and 12/14/25.</p> <p>Interview on 12/10/25 at 11:30 A.M., LPN #37 verified Resident #15 had no lymphedema boots on in the morning of 12/10/25 between 7:00 A.M and 11:00 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/10/25 at 12:30 P.M., the Director of Nursing, (DON) stated the physician orders in the MARs were not set up properly to permit the proper documentation as ordered. The DON verified the MAR had no documented evidence that the lymphedema boots were applied twice daily for an hour as ordered. The DON stated she expected the morning shifts would be between 7:00 A.M to 11:00 A.M. and the afternoon from 1:00 to 4:00 P.M. The DON verified the boots should not be applied overnight. The DON verified there was no documented evidence in any documentation that the lymphedema boots had been applied as ordered or the Resident #15 had refused.</p> <p>Interview on 12/11/25 at 11:45 A.M. Certified Nursing Assistant, (CNA) #61 stated she often worked with Resident #15, and had worked 12/07/25, 12/08/25, and 12/09/25. She stated she rarely observed the resident with the lymphedema boots applied and did not see the evening or night shift staff had applied the boots. The CNA # 61 stated she last applied the boots on 12/07/25 during day shift and verified the boots had not been applied on 12/08/25 and 12/09/25.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 1263891.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of fall investigations, observation, resident interview, staff interview, and policy review, the facility failed to ensure adequate supervision for residents who smoke. This affected three Residents (#12, #57, and #61) of three residents reviewed for smoking. The facility also failed to thoroughly investigate falls and implement appropriate fall interventions following falls to reduce and/or eliminate future falls. This affected five Residents (#01, #02, #25, #60, and #66) of five residents reviewed for falls. The facility census was 86. Findings include: 1) Review of Resident #12's medical record revealed an admission date of 12/30/21. Diagnosis included end stage renal disease, dependence on renal dialysis, anxiety disorder and tobacco use.</p> <p>Review of the care plan dated 09/15/25, revealed Resident #12 was at increased risk of injury related to smoking cigarettes. Interventions include providing supervision at all times while smoking, smoking assessment upon admission, quarterly and as needed, smoking items to be kept at the nurse's station, and the resident verbalized adherence to facility smoking policy and validated resident concerns.</p> <p>Review of the most recent Minimum Data Set (MDS) dated [DATE], revealed Resident #12 was cognitively intact.</p> <p>Review of the physician orders for Resident #12 dated 12/03/25, revealed the resident used tobacco products and the resident was to follow the facility's policy on location and time of smoking.</p> <p>Observation on 12/08/25 from 2:15 P.M. to 2:20 P.M., revealed Resident #12 was outside the facility at the end of the 100-hall seated in a wheelchair and smoking a cigarette with no staff present. Resident #12 started knocking on the door.</p> <p>Interview on 12/08/25 at 2:21 P.M., Certified Nursing Assistant (CNA) #65 confirmed Resident #12 was smoking outside the door of 100-hall and the door was locked to where the resident could not get back in the building. CNA #65 stated the smoking area was closed right now due to activities. CNA #65 stated she let Resident #12 outside to smoke and was going to let him in after she went to check on another resident. CNA #65 stated Resident #12 was an independent smoker.</p> <p>Review of the medical record for Resident #57 revealed an admission date of 09/18/25. Diagnoses included emphysema, heart disease, diabetes, and depression. During record review, there was no documented evidence of a care plan being developed for Resident #57.</p> <p>Review of the modification to the Quarterly MDS dated [DATE], revealed Resident #57 had no cognitive deficits and required minimum assistance with activities of daily living (ADL).</p> <p>Review of the medical record for Resident #61 revealed an admission date of 07/20/23. Diagnoses included sciatica, carpal tunnel, diabetes, anxiety, and depression.</p> <p>Review of a care plan dated 08/26/25, revealed Resident #61 was at increased risk of injury related to smoking cigarettes. Interventions included providing supervision at all times while smoking and a smoking apron was to be worn while smoking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 12/10/25 at 1:34 P.M., the DON verified the resident had falls on 06/24/25, 06/27/25, 07/05/25, 07/29/25, and three separate falls on 08/07/25. The DON verified there were no fall reports for Resident #02's falls on 07/05/25 and 08/07/25. The DON also verified there was no documented evidence of thorough investigations being completed to determine a root cause analysis and there was no new fall interventions implemented to reduce and /or eliminate future falls.</p> <p>During a subsequent interview on 12/16/25 at 12:54 P.M., the DON stated after a resident fell, the staff were expected to complete a post-fall assessment, investigate to find out why and how the fall happened, come up with a new fall intervention to help prevent future falls, and update the care plan.</p> <p>Review of the medical record for Resident #25 revealed an admission date of 10/22/25. Diagnoses included fracture of unspecified part of neck of left femur subsequent encounter for closed fracture with routine healing, Parkinson's disease with dyskinesia without mention of fluctuations, Alzheimer's disease, unspecified protein-calorie malnutrition, and congestive heart failure.</p> <p>Review of the plan of care initiated on 08/22/25 revealed Resident #25 was at risk for falls related to impaired cognition and physical mobility. Interventions included having the bedside table within reach, call light within reach, keeping room free of clutter, medication review, non-skid footwear at all times, and therapy to evaluate and treat as needed.</p> <p>Review of the progress note for Resident #25 dated 09/19/25, revealed the resident had a fall while attempting to sit in a chair. There was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>Review of the progress note dated 10/09/25, revealed Resident #25 was found on the floor next to a chair and reported that she slipped on a wet spot. There was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>Review of the progress note dated 10/19/25, revealed Resident #25 bumped into the meal tray cart and fell. There was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>Review of the five-day MDS assessment dated [DATE], revealed Resident #25 had severely impaired cognition. Resident #25 was assessed to require partial/moderate assistance for eating, oral hygiene, and toileting, substantial/maximal assistance for bed mobility and transfer, and was dependent on staff for bathing and dressing.</p> <p>Interview on 12/15/25 at 1:03 P.M., the DON verified Resident #25 had falls on 09/19/25, 10/09/25, and 10/19/25. The DON verified there were no new documented fall interventions implemented to reduce and /or eliminate future falls following the falls on 09/19/25, 10/09/25, and 10/19/25.</p> <p>Review of the medical record for Resident #60 revealed an admission date of 04/04/24. Diagnoses included Alzheimer's Disease with late onset, unspecified protein-calorie malnutrition, generalized anxiety disorder, hypertension, and unspecified intrascapular fracture of right femur subsequent encounter for closed fracture with routine healing.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Madeira		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 Kenwood Road Cincinnati, OH 45243	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the progress notes for Resident #60 from 04/11/25 to 12/15/25, revealed no documentation related to any changes to or review of fall interventions.</p> <p>Review of the progress note dated 04/11/25, revealed Resident #60 was found on the floor near his bed and was wrapped up in his blanket. There was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>Review of the plan of care revised on 08/06/25, revealed Resident #60 was at risk for falls related to Alzheimer's disease, dementia, impaired balance, impaired cognition, unsteady gait, and psychoactive medication use. Interventions included encouraging the resident to use call light, encouraging the staff to perform frequent checks and provide assistance as needed, fall assessments per facility policy, have commonly used articles within easy reach, monitoring for side effects of psychotropic medications and notifying physician of any irregularities, and therapy to evaluate as needed.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #60 had severely impaired cognition. Resident #60 was assessed to require setup assistance for eating, supervision for oral hygiene, toileting, dressing, bed mobility, and transfer, partial/moderate assistance for personal hygiene, and was dependent on staff for bathing.</p> <p>Interview on 12/15/25 at 12:56 P.M., the Director of Nursing (DON) verified Resident #60 had a fall on 04/11/25 and there was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>Review of the medical record of Resident #66 revealed an admission date of 10/09/24. Diagnoses included right hip fracture, chronic obstructive pulmonary disease (COPD), hypothyroidism, unsteadiness on feet, depression, cognitive communication deficit, and restless legs syndrome.</p> <p>Review of the progress note for Resident #66 dated 01/14/25, revealed the resident was found lying on the floor near her bed with her pants down. The resident stated she had just left the bathroom. The resident was assessed for pain and bruising, vitals were obtained, and the resident was assisted back to bed. Neurological checks were started, notifications made, and 911 was called for transfer to the hospital.</p> <p>Review of the Post Fall Evaluation for Resident #66 dated 01/14/25 revealed the resident experienced an unwitnessed fall. The fall occurred in the resident's room when she was walking from her bathroom to her bed with her pants around her ankles and without a walker. The resident was wearing non-skid footwear at the time of the fall but was not using her cane/walker at the time of the fall. The resident sustained a swollen knot to the back of the head and was sent to the hospital for evaluation.</p> <p>Review of the fall investigation dated 01/14/25, revealed Resident #66 had an unwitnessed fall. The immediate actions taken included assessing for pain and bruising, assessing vitals, and assisting the resident back into bed, euro checks were started, notifications made, and 911 called for transfer to the hospital. There was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the progress note for Resident #66 dated 08/01/25 at 1:38 A.M., revealed the resident had an unwitnessed fall in the bathroom. The resident was assessed and assisted back to bed and provided with as needed pain medication. The resident stated her right buttock hurt from the fall; however, there was no bruising noted.</p> <p>Review of the Post-Fall Evaluation, for Resident #66 dated 08/01/25, revealed the resident experienced an unwitnessed fall in the bathroom while attempting to ambulate to the toilet by herself. The resident fell trying to stand up from the toilet. The resident was using her cane/walker at the time of the incident; however, was ambulating in bare feet.</p> <p>Review of the progress note for Resident #66 dated 08/01/25 revealed the resident continued with pain throughout the shift. The physician was contacted and ordered the resident to receive a right hip x-ray and continue non-weight bearing status. The x-ray was completed and a right hip fracture was noted. The resident was sent to the hospital for evaluation and treatment.</p> <p>Review of the fall investigation dated 08/01/25 revealed Resident #66 was heard yelling for help. The resident was found sitting in front of the toilet and stated she fell while trying to get up from the toilet. The resident was assessed and assisted back to bed. The resident complained of pain in her right hip and buttocks. There was no redness or bruising. An as needed pain medication was provided. There was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>Review of a progress note for Resident #66 dated 11/18/25, revealed the resident was noted sitting on the edge of her bed while the nurse was passing medications and then noted sliding to the floor. The resident stated she was sliding on the floor and could not hold herself up. The resident was assessed and had no visible injuries or pain.</p> <p>Review of the fall investigation for Resident #66 dated 11/18/25, revealed the resident was noted sliding to the floor from her bed. The resident stated she could not hold herself up. The resident was assessed and had no visible injuries and no pain. There was no new documented fall interventions implemented to reduce and /or eliminate future falls.</p> <p>Review of the comprehensive MDS assessment dated [DATE], revealed Resident #66 had severely impaired cognition. The resident required supervision for eating, substantial/maximal assistance for bed mobility, was dependent for transfers, toileting and bathing.</p> <p>Interview on 12/15/25 at 1:10 P.M., the Director of Nursing (DON) verified there were no new documented fall interventions for Resident #66's falls on 01/14/25, 08/01/25, and 11/18/25.</p> <p>Review of the facility policy titled Managing Falls and Fall Risk, reviewed 04/28/25, revealed staff would identify interventions related to the resident's risks and causes to try to prevent the resident from falling. The policy also indicated if a resident continued to fall, staff would re-evaluate the situation and decide whether it would be appropriate to continue or change interventions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the policy named, Falls and Fall Risk, Managing Policy dated 04/28/25 revealed, based on previous evaluations and current data, the staff would identify interventions related to the resident's risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending Physician/Nurse Practitioner (NP) as needed, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If falling reoccurs despite initial interventions, staff may implement additional or different interventions or indicate why the current approach remains relevant. If the resident continued to fall, staff would re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 1264360.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure residents received three meals a day. This affected one (Resident #19) out of three residents reviewed for meal assistance. The facility census was 86. Findings Include: Observation on 12/10/25 at 2:10 P.M., revealed Resident #19 had not received their lunch at this time. Interview on 12/10/25 at 2:11 P.M., with Resident #19 confirmed they did not receive lunch at this time. Resident #19 stated that they requested a ham sandwich and a bowl of soup from the alternative menu. Interview on 12/10/25 at 2:27 with the Director of Nursing (DON), confirmed Resident #19 did not receive their lunch. Review of the facility policy titled, Mealtimes and Frequency revealed the facility will provide at least three meals daily at regular times. The policy also states lunch will be served daily at 12:30 P.M. This deficiency represents non-compliance investigated under Complaint Number 1264367.</p>

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure therapeutic diets were received, as ordered by the physician. This affected four Residents (#48, #51, #53 and #01) of four residents reviewed for therapeutic diets. The total facility census was 86. Findings Include: 1) Record review of Resident #48 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #48 include cerebral infarction, malnutrition, and end stage renal disease.</p> <p>Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed Resident #48 had intact cognition and required supervision with meals. The resident received dialysis treatments three times a week at a dialysis center. The resident received a renal diet, with double portions of protein at breakfast.</p> <p>Observation of Resident #48's breakfast tray and review of the meal ticket on 12/11/25 at 8:10 A.M., revealed an order for renal diet. Resident #48 received one portion of egg with cheese, eight ounces of milk and one portion sausage patty. Interview at the same time, Resident #48 verified he received one portion of egg and cheese, sausage and milk. He stated there were no restrictions that he knew of on his diet, including snacks. He stated for snack time, he received packaged potato chips. Resident #48 stated he was not aware of being on a renal diet.</p> <p>Interview on 12/11/25 at 8:11 A.M., Certified Nursing Assistant, (CNA) #42 verified the Resident #48's meal ticket listed renal diet with double portions at breakfast. CNA #42 verified the resident did not receive double portion protein and received cheese, milk and sausage. CNA #42 stated she did not know what foods were restricted on a renal diet</p> <p>Review of therapeutic diet definition sheet provided by the facility on 12/11/25 10:00 A.M., revealed the renal diet was to avoid milk, cheese, potatoes, tomatoes, vegetable juice and sausage. Observation of Resident #48's lunch tray on 12/11/25 at 1:15 P.M., revealed the resident received a ham and cheese sandwich and vegetable soup for lunch. The resident consumed all the food. Interview on 12/11/25 at 1:25 P.M., CNA # 42 verified Resident #48 received a ham and cheese sandwich and vegetable soup. CNA #42 verified the resident consumed the ham and cheese sandwich and vegetable soup.</p> <p>Interview on 12/11/25 at 1:30 P.M., Resident #48 verified he received and consumed the ham and cheese sandwich and vegetable soup. Resident #38 stated he did not know what foods were restricted to a renal diet.</p> <p>Interview on 12/16/25 at 10:38 A.M., Dietary Technician, (DT) #315 verified Resident #48 had physician orders for a renal diet which restricted sausage, ham, cheese, vegetable juice, and milk. DT #315 verified Resident #48 was ordered to receive double portions of protein at breakfast and should have foods on the renal diet at snack time.</p> <p>2) Record review of Resident #51 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #51 include diabetes, morbid obesity, malnutrition, tachycardia, and hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the MDS comprehensive assessment dated [DATE], revealed Resident #51 had intact cognition and required set up assistance with eating.</p> <p>Observation on 12/10/25 at 8:45 A.M., revealed the Resident #51 received scrambled eggs with cheese, eight ounces of milk and sausage gravy. Resident #51's meal ticket revealed an order for renal diet with dislikes listed as milk, and orange juice. Interview with Resident #51 at the same time verified she received eggs and cheese, sausage gravy and milk. The resident stated she did not know why she was on a renal diet. Resident #51 stated for snack time, she had no choices of a renal diet food item and snacks included high sodium prepackaged snacks, including potato chips.</p> <p>Interview on 12/10/25 at 8:46 A.M., Licensed Practical Nurse, (LPN) # 46 verified Resident #51 was on a renal diet and received eggs and cheese, sausage gravy and milk.</p> <p>Observation on 12/11/25 at 8:15 A.M., revealed Resident #51 received one portion of eggs with cheese, eight ounces of milk and one portion sausage patty. Interview with Resident #51 at the same time verified she received an egg and cheese omelet, sausage and milk. She stated she often received orange juice.</p> <p>Interview on 12/11/25 at 8:16 A.M., LPN # 46 verified the Resident #51's meal ticket listed renal diet and the resident received an egg and cheese omelet, sausage and milk.</p> <p>Observation on 12/11/25 at 1:25 P.M., Resident #51 received a ham and cheese sandwich and vegetable soup at lunch. The resident consumed all the food.</p> <p>Interview on 12/11/25 at 1:25 P.M., LPN # 51 verified Resident #51 received and consumed ham and cheese sandwich and vegetable soup.</p> <p>Review of therapeutic diet definition sheet provided by the facility on 12/16/25 at 10:38 A.M., revealed the renal diet was to avoid milk, cheese, potatoes, tomatoes, vegetable juice and sausage. Interview with DT #315 at the same time, verified Resident #51 had physician orders for a renal diet which restricted sausage, ham, cheese, vegetable juice, milk and salty snacks. DT #315 verified Resident #51 was ordered to receive double portion proteins at breakfast and should have food on the renal diet at snack time.</p> <p>Review of the active December 2025 physician orders, revealed Resident #51 was ordered for renal diet with listing of limit bananas, tomato, potato and orange juice.</p> <p>3) Record review of Resident #53 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #53 include dementia, malnutrition, nonceliac gluten sensitivity, abdominal distension, symptoms involving the digestive system and abdomen. Resident #53 resided in the secured Memory Care Unit.</p> <p>Review of the MDS comprehensive assessment dated [DATE], revealed Resident #53 had intact cognition and required set-up assistance for eating.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/11/25 at 7:38 A.M., [NAME] #103 verified he had no knowledge of the specific foods that were restricted on Residents #51 and #48's renal diets and had not prepared alternates for the egg and cheese food. [NAME] #103 stated he had no knowledge of Resident #53's special diet and did not prepare gluten and lactose free foods.</p> <p>Observation on 12/11/25 at 8:25 A.M., revealed Resident #53 received one portion of eggs with cheese and eight ounces of a nutritional supplement. The supplement listed milk protein concentrate as a main ingredient. Resident #53's meal ticket revealed a regular diet. There were no food restrictions except chocolate, peanuts and popcorn. There was no notation of any restricted foods due to gluten and lactose intolerance.</p> <p>Interview on 12/11/25 at 8:28 A.M, Resident #53 verified she received eggs and cheese, sausage and the supplement. She stated she had been gluten and lactose sensitive for years and knew she could not have milk products and wheat products, including cheese, toast, and milk. She stated that after she consumes her supplement, she had strong pain in her abdomen. She stated she gets similar food served to her all the time and her family brought in gluten and lactose free foods. Resident #53 stated she did not want to eat the food provided by the facility.</p> <p>Interview on 12/11/25 at 8:30 A.M., LPN #46 verified Resident #53's meal ticket did not list gluten and lactose restricted foods or listed as a part of the diet order. LPN #46 verified the facility serves Resident #53 gluten and lactose type foods daily. LPN #46 verified Resident #53's supplement ingredients listed milk protein concentrate as a main ingredient, and Resident #53 at time reported some abdominal discomfort after drinking the supplement.</p> <p>Observation on 12/11/25 at 1:25 P.M. with LPN #46, revealed Resident #53 received a ham and cheese sandwich and vegetable soup for lunch. The resident refused the ham sandwich and stated she knew not to consume milk and wheat products. Interview with LPN #46 and CNA #52 at the same time, verified Resident #53 received ham and cheese sandwich.</p> <p>Interview on 12/11/25 at 1:30 P.M, Resident #53 verified she received the ham and cheese sandwich and refused it.</p> <p>Interview on 12/16/25 at 10:38 A.M., DT #315 verified Resident #53 had physician orders for a regular gluten and lactose free diet due to allergy. DT #315 verified the residents should not receive wheat and milk products, including a supplement listed as milk protein concentrate.</p> <p>Review of the active December 2025 physician orders revealed Resident #53 was ordered to receive a regular diet with gluten and lactose free diet for allergies.</p> <p>4) Review of the medical record revealed Resident #01 was admitted to the facility on [DATE]. Diagnoses included generalized anxiety, auditory hallucinations, major depressive disorder, unspecified dementia, cognitive communication deficit, bipolar disorder and unspecified psychosis.</p> <p>Review of the care plan for Resident #01 dated 08/22/25, revealed the resident was at risk for malnutrition/alteration in nutritional status and was ordered a mechanically altered diet/thickened liquids related to dysphagia. Interventions included monitoring the resident's ability to chew/swallow, reporting any changes to nurse and medical provider, providing and serve diet as ordered and the Registered Dietician (RD) to evaluate and make diet change recommendations as needed (PRN).</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the physician orders dated 11/03/25, revealed Resident #01 was ordered to receive a regular diet, mechanical soft, cut up foods texture, nectar thickened - no straws consistency.</p> <p>Review of the most recent MDS assessment dated [DATE], revealed Resident #01 had moderately impaired cognition, supervision with eating, dependent with toileting and bathing.</p> <p>Observation of Resident #01 on 12/10/2025 at 10:44 A.M. with CNA #42, revealed the resident was sitting up in bed with a can of soda sitting on the bedside table with a straw inside. CNA #42 stated Resident #01 had been drinking out of straws for weeks, and she had not been thickening the resident's liquids. Resident #01 stated she had been using straws for weeks and no one had been thickening her liquids that she is consuming.</p> <p>Interview on 12/10/25 at 10:53 A.M. with LPN #81, confirmed Resident #01 had an order for thickened liquids and no straws but LPN #81 stated she was not aware of the order for no straws.</p> <p>Observation and interview on 12/11/2025 at 9:58 AM with LPN #81, confirmed the staff must follow the physicians order for Resident #01 not to have straws and confirmed there was a straw in the resident's cup sitting on her bedside table at the time of this observation.</p> <p>Observation and interview on 12/11/25 at 1:15 P.M., revealed Resident #01 was sitting up in bed and had two cups sitting on her bedside table with straws in the cups. CNA #42 verified Resident #01 had straws in her drinks.</p> <p>Review of the physician orders dated 12/11/25, revealed Resident #01 had an order for therapy to do a one-time speech evaluation for diet.</p> <p>Review of the nurse's progress note for Resident #01 dated 12/11/25, revealed a nurse spoke with a Hospice nurse and informed her that the resident has been non-compliant with the current diet order and a new order was received for a one-time speech therapy evaluation. The Nurse Practitioner (NP) and the resident were notified, and the order had been entered and implemented.</p> <p>Interview on 12/15/25 at 1:15 P.M., the Director of Nursing (DON) confirmed that all staff should document if a resident was refusing to follow diet orders and to set up a care conference.</p> <p>Review of the medical record revealed there was documentation of Resident #01 refusing to follow diet orders.</p> <p>Review of facility policy, Accuracy of Quality of Tray Line Service, undated, revealed the meal will be checked against the therapeutic diet spreadsheet to assure that the foods are served as listed on the menu. The staff will refer to the meal identification ticket for food dislikes, allergies and other details. Each meal would be checked for proper portion sizes.</p> <p>Review of facility policy, Therapeutic Diets, undated revealed a tray identification system is established to ensure each resident receives his or her diet.as ordered.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to maintain a safe, functional, and sanitary environment. This directly affected two Residents (#56 and #59) and had the potential to affect 11 additional residents housed in the 500 hall out of 13 residents reviewed for environment. The facility census was 86. Findings include:</p> <p>Review of the medical record for Resident #56 revealed an admission date of 07/03/24. Diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified protein-calorie malnutrition, encephalopathy, acute kidney failure, type two diabetes mellitus without complications, and hyperlipidemia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had severely impaired cognition. Resident #56 was assessed to require supervision for eating and bed mobility, partial/moderate assistance for oral hygiene and toileting, and substantial/maximal assistance for bathing, dressing, and personal hygiene.</p> <p>Review of the medical record for Resident #59 revealed an admission date of 10/14/21. Diagnoses included Alzheimer's disease with late onset, unspecified severe protein-calorie malnutrition, cerebrovascular disease, and anxiety disorder.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #59 had severely impaired cognition. Resident #59 was assessed to require setup assistance for eating, partial/moderate assistance for bed mobility, and was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and transfer.</p> <p>Observation on 12/08/25 at 12:00 P.M. revealed the carpet in the hallway of the 500 unit to be heavily soiled at each entrance to rooms 501, 502, 503, 504, 505, 509, 510, 513, 514 and 515. There was a three-foot-long stain at the start of the hallway carpet, near room [ROOM NUMBER]. There were three ceiling vents in the 500 hallway with the grids with heavily soiled brown debris hanging down from the grids.</p> <p>Observation on 12/11/25 at 1:01 P.M. in the room shared by Residents #56 and #59 revealed a baseball sized hole in the lower section of the wall near the bathroom door. The baseboard was also missing along the walls in the room in several areas. Interview at the time of the observations with State Tested Nursing Assistant (STNA) #60 verified the findings.</p> <p>Interview on 12/11/25 at 3:10 P.M., Environmental Director (ED) #03 verified the unit 500 hallway carpet was heavily soiled, and the hallway ceiling vents were heavy soiled with brown debris. ED #03 stated there was no carpet machine to clean the carpets. There was only a vacuum to clean the carpets. He had no knowledge of when the carpets were last shampooed to remove the heavily soiled area.</p> <p>Review of the facility policy titled Homelike Environment, revised 05/2017, revealed residents would be provided with a safe, clean, comfortable and homelike environment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Madeira		STREET ADDRESS, CITY, STATE, ZIP CODE 5970 Kenwood 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Complaint Numbers 2627584, 1264367, and 1264367.		