STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365196	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Ridge Healthcare Center	5501 Verulam Cincinnati, OH 45213

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident interview, staff interview and facility policy review, the facility failed to ensure a resident was provided with a comfortable environment when the air conditioning unit was not maintained in working order. This affected one (#65) of four residents reviewed for environment. The facility census was 82. Findings included: Review of the admission record for Resident #65 with admission date of 02/20/25 and diagnoses including [NAME] fascial fibromatosis and paroxysmal atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 04/22/25, revealed Resident #65 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Interview on 05/26/25 at 11:07 A.M., with Resident #65 stated the air conditioning (AC) unit in their room did not work correctly. Resident #65 stated the room would get hot on warm days. Resident #65 stated they had informed staff, and the Director of Maintenance (DOM) had come to their room and agreed the unit was blowing warm air. Observation on 05/29/25 at 11:10 A.M., of the AC unit in Resident #65's room, revealed the AC unit did not blow cool air. The AC unit was turned on to the lowest setting. After it ran for a few seconds, the AC unit was turned to level 8 and the AC unit still did not blow cool air. Interview on 05/29/25 at 11:11 A.M., with Resident #65 stated the DOM had informed them the day prior that the AC unit would be replaced. Observation on 05/29/25 at 2:16 P.M., with the DOM tested the AC unit in Resident #65's room and confirmed the unit was not blowing cold air and that the unit needed to be replaced. The DOM stated he did not recall speaking with Resident #65 about the AC unit; however, he may have forgotten and did not come back and look at the unit. At 2:18 P.M., Resident #65 entered the room and stated they had spoken with the DOM about the AC unit a couple of weeks prior. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/30/25 at 2:07 P.M., with the Director of Nursing (DON) stated the expectation was when equipment was broken, a work order would be initiated, and the equipment should be fixed or replaced immediately, depending on the type of equipment. The DON said they were unaware of any complaints of non-working AC units in the hall where Resident #65 resided. Interview on 05/29/25 at 3:36 P.M., with the Executive Director (ED) stated the temperatures in the facility were a high priority. The ED stated when there were complaints of AC units were not working; the facility ensured the residents were comfortable and offered a fan or room change until the AC unit could be repaired or replaced. Review of the undated policy titled, Resident Rights, indicated it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. This deficiency represents noncompliance investigated under Complaint Number OH00164412.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to identify a potential elopement and take action for finding a resident, when a resident's empty wheelchair was found on the facility curb in the rain. This affected one (#34) of one resident reviewed for potential elopement. The facility census was 82. Findings included: Review of the medical record revealed Resident #34 was admitted on [DATE] with diagnoses including peripheral vascular disease, manic depression, and psychotic disorder. Review of the discharge Minimum Data Set (MDS) assessment, dated 09/09/24, revealed Resident #34 had independent cognitive skills for daily decision-making and had no short-term memory problems per a staff assessment of mental status (SAMS). The MDS indicated the resident utilized a manual wheelchair for mobility and independently mobilized the wheelchair 150 feet in a corridor or similar space. Review of the quarterly MDS, dated [DATE], revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident utilized a wheelchair for mobility and required staff assistance to mobilize the wheelchair 150 feet in a corridor or similar space. Review of Resident #34's Care Plan Report included a focus area, revised on 12/12/24, that indicated the resident was known to leave the building without signing out despite provided education. Interventions directed staff to encourage the resident to maintain as much independence and control/decision making as possible and praise any indication of progress with behaviors. Review of nursing Progress Note, dated 09/30/24 at 7:05 PM, revealed Resident #34 left the facility without notifying staff or signing out at approximately 2:45 P.M. that day. Per the note, the resident's (empty) wheelchair was discovered on a facility curb while it was raining outside. The note indicated staff brought the wheelchair inside the facility and notified the Executive Director (ED) and Resident #34's guardian. Per the note, the resident returned to the facility that day at 6:25 P.M. as a passenger in another resident's vehicle. The note revealed staff notified the driving resident of the dangers of having other residents in the vehicle with them. The note indicated staff assisted Resident #34 out of the vehicle and into the facility. Per the note, Resident #34 refused an assessment of their vital signs and expressed a desire to leave the facility again to see a family member. Review of physician Progress Note, dated 09/30/24 at 7:00 P.M., revealed a physician was notified that Resident #34 left the facility without signing out or notifying anyone and returned with no apparent injuries. The Progress Note further indicated the facility ED was aware. Interview on 05/28/25 at 1:02 P.M., with Certified Nurse Aide (CNA) #10 stated they had not previously known Resident #34 to leave the facility without notification. CNA #10 stated if a resident was not in their room, they would notify the nurse and then begin looking for the resident in the facility. CNA #10 stated residents were to sign out when they left the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/28/25 at 1:15 P.M., with Licensed Practical Nurse (LPN) #11 stated if they identified a resident who was missing, they would search the building grounds and call the ED and the Director of Nursing. LPN #11 stated they would also check to see if the resident had signed out. Interview on 05/28/25 at 3:42 P.M., with the ED stated she remembered calling Resident #34's guardian after the incident wherein the resident did not notify staff they were leaving the facility. The ED stated they reminded Resident #34 to sign out before and after the incident in question. The ED stated that, on the day of the incident in question, it was raining outside, and staff identified a wheelchair belonging to Resident #34 was on the curb of the property. The ED stated Resident #34 was unable to walk. The ED stated she expected a resident to sign out if leaving the facility and, if a resident was unaccounted for, she expected the elopement process to be initiated. Interview on 05/30/25 at 12:29 P.M., with the ED stated she expected residents to sign out if they were leaving the property and for the facility to have no elopements. Review of the undated policy titled Elopement Prevention and Management Overview, indicated, Elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident at risk for harm or injury. A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. This deficiency represents non-compliance investigated under Complaint Number OH00164628.