STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365218	A. Building B. Wing	01/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ash Care Center	4900 Cooper Road Cincinnati, OH 45242

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, resident representative interview, staff interview, and review of the facility policy, the facility discharged a resident from the facility without a physician's order or proper documentation of a rationale for the facility-initiated discharge. This affected one (Resident #42) of two residents reviewed for transfer or discharge. The facility census was 51 residents. Findings include: Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including unspecified encephalopathy, dementia, mood affective disorder and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 10/03/24 revealed the resident had severe cognitive impairment and required staff assistance with activities of daily living (ADLs.) Review of the progress notes for Resident #42 dated 08/18/24 to 01/10/25 revealed they did not include documentation of a discharge notice from the facility to the resident nor did they include any documentation of a reason for discharge. Review of the physician's orders for Resident #42 dated 08/18/24 to 01/10/25 revealed there was no discharge order for the resident. Review of social services progress note for Resident #42 dated 01/10/25 per Social Service Director (SSD) #31 revealed the resident was transferred on 01/10/25 to another facility. Resident #42 was picked up by receiving facility transport and the resident's responsible party was notified. Review of the facility initiated thirty-day discharge notice for Resident #42 dated 01/10/25 revealed the notice was sent to Resident #42 and Resident #42's responsible party via certified mail on 01/13/25. Review of the notice revealed Resident #42 was being discharged immediately because the safety of other individuals in the facility was endangered. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/13/25 at 9:46 A.M. with Resident #42's responsible party revealed SSD #31 called the resident's brother on 01/08/25 and told him the facility was discharging the resident to another nursing home immediately. Resident #42's responsible party confirmed he did not speak directly with anyone from the facility but received a text message from the resident's brother on 01/08/25 indicating the facility informed him the resident would be discharged to another local nursing facility on 01/10/25. Resident #42's responsible party confirmed the facility did not provide any written notice the resident would be discharged . Interview on 01/13/25 at 11:00 A.M. with the Administrator confirmed the facility sent a 30-day discharge notice via certified mail to Resident #42's responsible party on 01/13/25 after the resident had already been discharged from the facility. Interview on 01/15/25 at 9:20 A.M. with the Medical Director (MD) confirmed the either the Administrator or the Director of Nursing (DON) had called her the week prior and notified her of Resident #42's discharge. The MD confirmed she did not make a note in the resident's medical record stating the basis for the resident's discharge from the facility nor did she write a discharge order. Review of the facility policy titled Transfer and Discharge revised 01/13/25 revealed the facility would permit each resident to remain in the facility and would not initiate transfers or discharges for the residents from the facility, except in limited circumstances. For non-emergency transfers or discharges the facility would document the reasons for the transfer or discharge in the resident's medical record. The facility staff would document any danger to the health or safety of the resident or other individuals that failure to transfer or discharge would pose. The physician should document medical reasons for transfer or discharge in the medical record, when the reason for transfer or discharge was for any reason other than nonpayment of the stay or the facility ceasing to operate. A copy of the physician's order for the discharge should be attached to the discharge notice.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, resident representative interview, staff interview, and review of the facility policy, the facility discharged a resident from the facility and failed to a written notice of discharge to the resident and resident representative before the discharge. This affected one (Resident #42) of two residents reviewed for transfer or discharge. The facility census was 51 residents. Findings include: Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including unspecified encephalopathy, dementia, mood affective disorder and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 10/03/24 revealed the resident had severe cognitive impairment and required staff assistance with activities of daily living (ADLs.) Review of the progress notes for Resident #42 dated 08/18/24 to 01/10/25 revealed they did not include documentation of a discharge notice from the facility to the resident nor did they include any documentation of a reason for discharge. Review of the physician's orders for Resident #42 dated 08/18/24 to 01/10/25 revealed there was no discharge order for the resident. Review of social services progress note for Resident #42 dated 01/10/25 per Social Service Director (SSD) #31 revealed the resident was transferred on 01/10/25 to another facility. Resident #42 was picked up by receiving facility transport and the resident's responsible party was notified. Review of the facility initiated thirty-day discharge notice for Resident #42 dated 01/10/25 revealed the notice was sent to Resident #42 and Resident #42's responsible party via certified mail on 01/13/25. Review of the notice revealed Resident #42 was being discharged immediately because the safety of other individuals in the facility was endangered. Interview on 01/13/25 at 9:46 A.M. with Resident #42's responsible party revealed SSD #31 called the resident's brother on 01/08/25 and told him the facility was discharging the resident to another nursing home immediately. Resident #42's responsible party confirmed he did not speak directly with anyone from the facility but received a text message from the resident's brother on 01/08/25 indicating the facility informed him the resident would be discharged to another local nursing facility on 01/10/25. Resident #42's responsible party confirmed the facility did not provide any written notice the resident would be discharged . Interview on 01/13/25 at 11:00 A.M. with the Administrator confirmed the facility sent a 30-day discharge notice via certified mail to Resident #42's responsible party on 01/13/25 after the resident had already been discharged from the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/15/25 at 9:20 A.M. with the Medical Director (MD) confirmed the either the Administrator or the Director of Nursing (DON) had called her the week prior and notified her of Resident #42's discharge. The MD confirmed she did not make a note in the resident's medical record stating the basis for the resident's discharge from the facility nor did she write a discharge order. Review of the facility policy titled Transfer and Discharge revised 01/13/25 revealed the facility would provide written notice of the discharge to the resident and the resident's representative of the discharge as soon as practicable before the discharge.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure oxygen was administered as ordered by a physician and in accordance with professional standards of practice for respiratory care. This affected three (Residents #3, #14, and #18) of three residents reviewed for oxygen administration. The facility census was 51 residents. Findings include: 1. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including acute infarction of intestine due to gunshot wound, cocaine abuse, opioid dependence, bipolar disorder, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, severe protein-calorie malnutrition and pulmonary hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 12/01/24 revealed the resident was cognitively intact and required assistance with activities of daily living (ADLs). Review of the plan of care for Resident #14 dated 12/18/24 revealed the resident had altered respiratory status related to COPD with a goal to maintain a normal breathing pattern. The primary interventions included administration of inhaler as ordered, medications as ordered, and oxygen as ordered. Review of physician's orders for Resident #14 revealed an order dated 11/21/24 for the resident to receive oxygen at two to four liters per minute (LPM) per nasal cannula (NC) to keep oxygenation levels above 92 percent (%) and for the oxygen tubing to be changed every week and dated. Observation on 01/13/25 at 8:45 A.M. revealed Resident #14 was in bed and receiving oxygen via NC at two LPM. The tubing and NC were dated 01/03/25 and there was no signage on the door that indicated oxygen was in use. Interview on 01/13/25 at 8:45 A.M. with Registered Nurse (RN) #77 confirmed Resident #14's oxygen tubing and NC were outdated and there was no signage on the door indicating oxygen was in use. 2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including COPD, hypertension, alcohol dependence and depression. Review of the MDS assessment for Resident #18 dated 11/18/24 revealed the resident had moderate cognitive impairment and required supervision and assistance with ADLs. Review of the care plan for Resident #18 dated 11/14/24 revealed the resident was at risk due to altered respiratory status related to COPD with a goal to maintain normal a breathing pattern. The primary interventions included administration of medications as ordered, elevated head of bed as needed for shortness of breath, observe for signs and symptoms of respiratory distress and notify the physician as needed, and teach resident relaxation techniques. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician's orders for Resident #18 revealed an order dated 01/02/25 for the resident to receive oxygen at two LPM per nasal cannula. There was no order to change the oxygen tubing and nasal cannula. Observation on 01/13/25 at 9:00 A.M. revealed Resident #18 was receiving oxygen at two LPM and oxygen tubing and nasal cannula were undated. There was no sign on the door that indicated oxygen was in use. Interview on 01/13/25 at 9:00 A.M. with RN #77 confirmed Resident #18 did not have a physician order for the tubing and nasal cannula to be changed every seven days. RN #77 confirmed Resident #18's tubing and nasal cannula were undated and she was unsure when they were due to be changed and there was no signage on the door indicating oxygen was in use. 3. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including osteoarthritis, morbid obesity, hypertension, congestive heart failure, hyperlipidemia, asthma and chronic viral hepatitis C. Review of the MDS assessment for Resident #3 dated 10/27/24 revealed the resident was cognitively intact and required supervision with ADLs. Review of the care plan for Resident #3 dated 05/18/23 revealed the resident was at risk due to altered cardiac output related to congestive heart failure, hypertension and hyperlipidemia with a goal to be free of signs and symptoms of cardiac complications. The primary interventions were to administer medications and oxygen as ordered. Review of physician's orders for Resident #3 revealed the resident did not have an order for the administration of oxygen nor did the resident have an order to have the tubing and NC changed every seven days. Observation on 01/13/25 at 9:10 A.M. revealed Resident #3 was in his room in his wheelchair and was receiving oxygen via an oxygen concentrator at four LPM with oxygen tubing and NC dated 11/29/24. There was no sign on the door that indicated oxygen was in use. Interview on 01/13/25 at 9:05 A.M. with Registered Nurse (RN) #77 confirmed Resident #3 did not have physician orders for the administration of oxygen or for the oxygen tubing and NC to be changed. RN #77 confirmed Resident #3 was receiving oxygen at four LPM and the tubing was outdated and there was no signage on the door that indicated oxygen was in use. Interview on 01/14/25 at 3:55 P.M. with the Director of Nursing (DON) confirmed oxygen tubing and nasal cannula are to be changed and dated every seven days. Review of the facility policy titled Oxygen Administration revised October 2010 revealed the facility would provide safe oxygen administration which included to verify there was a physician's order in place for oxygen administration and to place an oxygen in use sign outside the resident's door.